Just a Nurse:

A critical exploration of how general medical nurses regard their practice

Submitted by

Annette Marlow RN, RM, BN, Grad Dip. F&CH

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DECLARATION

It is my assertion that this thesis does not include, without acknowledgement, any material previously published by another person for a degree or diploma in any other tertiary institution.

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Annette Marlow

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ABSTRACT

It is argued that the provision of fundamental nursing care is the very essence of what it means to be a nurse. However, in contemporary health care contexts the pursuit of increased efficiencies has seen the concern with care diminish. The literature indicates that in these circumstances, the key providers of care to patients in hospitals, general medical nurses, are less than happy with the situation. In part this is reflected in the problems currently facing health care agencies with recruiting and retaining nurses. In a climate where recruitment and retention of experienced nurses is a major political issue, it is interesting to note that within the nursing literature, there is a virtual absence of research which addresses the issues and concerns of nurses who choose to work in a general medical ward setting. In order to begin the process of addressing this hiatus, this study utilized a critical research method to explore the issues and concerns of five nurses who work as general medical nurses. Consistent with research that has a critical intent, the nurses engaged in 'critical dialogues' which were analysed and developed into a discussion paper. The discussion paper was then returned to the nurses, and the issues raised were subjected to considerable debate when the participants subsequently met as a group.

The findings of the research provide keen insights into the experiences, issues and concerns of this group of general medical nurses. They highlight the operation of an array of conflicting interests which negatively impact on the capacity of general medical nurses to provide quality nursing care. Significantly, the perceived lowering of standards of patient care has caused the participants of this study to question their integrity and identity as nurses. However, given the opportunity to engage in a dialogue and to critically reflect on the issues raised, the nurses developed new insights into their situation which affirmed their worth as general medical nurses.

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KEY TO TRANSCRIPTS AND QUOTES

[ ]	Added to clarify meaning and/or context.
...	Words, phrases or sentences omitted.
Italics	Used for interview and discussion group transcript material.

CONTENTS

CHAPTER 1 - INTRODUCTION

Let me tell you the secret that has led me to my goal: my strength lies solely in my tenacity (Pasteur, 2003).

Throughout my childhood I did not aspire to be a nurse but rather a teacher. However at that crucial time in grade 12 when a decision was to be made, I chose nursing. I can't remember why; perhaps it was because the hospital was close by and the prospect of a fortnightly pay packet seemed promising. Twenty-two years ago seems like yesterday. I can remember those first few years vividly. The first time a patient died, caring for people with dementia, trying to stay awake on night duty, hospital food, and of course the hierarchy. All student nurses knew their place and what was expected of them. For me however, the most important aspect of my nursing career has been the friendships formed. In hindsight I was obviously craving collegiality, and life as a student nurse followed very nicely on from that of a Catholic girl's school. I was never a leader; always a follower. Fortunately I had two very outgoing friends who prevented me from leading a somewhat ordinary existence.

As a registered nurse I have worked in foreign countries, have completed my Certificate in Midwifery, gained a Bachelor of Nursing and a Postgraduate Diploma in Family and Child Health. I have worked as a paediatric nurse as well as a community health nurse. Striving to become a triple-certificate nurse with all of those badges pinned to one's white uniform was considered the norm. The reality was however, that in between travel and courses I always returned to the one ward at the local hospital—a medical ward. I felt very at home on a general medical ward. I loved the continuity of care, the pace and the intricacies of everyday practice. The knowledge I had gained through experience and continuing education enabled me to appreciate the more fundamental aspects of nursing care. The so called 'basic tasks' of nursing—like cleaning a patient's teeth, ensuring a patient's privacy and dignity whilst attending to their hygiene needs, or feeding a patient in an unhurried manner—became my focus.

It is only now that I acknowledge through reflection that I have struggled with articulating my preference for working on a general medical ward. When my friends were specializing in Intensive Care Nursing, or becoming autonomous practitioners within the community, I found myself saying "Oh I'm just a nurse; I work on the wards". In hindsight, as a medical ward nurse I was not motivated by promotion away from the bedside: I had found my niche. I often wondered if other registered nurses working in similar environments felt as I did. I became interested in my colleagues' perceptions of their experiences as general medical ward nurses, which in turn motivated me to undertake this research and to ask the question—what are the key issues and concerns that general medical nurses, working in an acute hospital, identify as impacting on their practice?

In order to provide myself with a comprehensive understanding of the role and function of general medical nursing a thorough review of the literature was conducted, which is outlined in Chapter 2. For the purposes of this study general medical nursing is defined as nursing care given by registered general nurses on general medical wards. The literature provided me with a pertinent array of both international and Australian scholarship which gave me the impetus to investigate the general medical nurse's experience within the Tasmanian environment. To date no other study has been identified which does this. Following the review of literature, I chose a research method which was appropriate for meeting the objectives of this study, a discussion of which is reviewed in Chapter 3. Chapter 4 comprises an analysis of the data generated from the study. There follows a discussion of the research findings in Chapter 5, and reflections on the research process in Chapter 6.

CHAPTER 2 - LITERATURE REVIEW

Introduction

This review will explore the themes which have emerged within the literature concerning the role and attributes of the general medical nurse. Firstly I will begin by locating the registered general nurse within a professional domain. I will then focus specifically on the literature which pertains to the general nurse within the context of a general medical ward setting. The act of caring, the notion of basic nursing care, and the devaluation of ward work will be reviewed, followed by the issues surrounding intraoccupational status and prestige. The impact of the introduction of extended-care assistants will be reviewed in an attempt to facilitate understanding of the role of the general medical nurse. Finally, a brief synopsis regarding the plight of the general practitioner will be provided to add another dimension to the discussion of what it might mean to be a general medical nurse.

Nursing within a contemporary hospital context in 2003

Economic rationalist imperatives are shaping the provision of health care as today the need to reduce costs is high on the health care agenda (Irvine et al., 1998). This necessarily has implications for nurses, because according to Carney-Badovinac et al., (1999, p.196) 'rising health care costs and shrinking reimbursement budgetary constraints have caused a restructuring in the delivery of nursing in acute care hospitals'. A reduction in expenditure means that facilities are restructuring and downsizing and, as a result, many hospital administrators have to employ unlicensed care assistants rather than registered nurses to provide 'bedside care' (Solecki, 1998; Bradshaw, 1999; Carney-Badovinac et al., 1999). Concomitant with these changes, nursing staff shortages within hospital settings have been increasingly noted in the literature (Chard, 2000; Morrison et al., 2000; Jackson et al., 2001). Consequently nursing and nurses are facing unprecedented challenges in an environment that is undergoing constant change, with fewer resources than in the past (Barr & Sines, 1996; Brusman-Zaidel, 2000; Begat & Severeinsson, 2001; Jackson et al., 2001).

Restructuring initiatives have led to the introduction of shorter hospital stays and associated increases in patient acuity (Jackson et al., 2001), Hence, patients are treated more quickly and their care is more demanding, due to a trend to admit only those people with the most severe illnesses (Meyer, 1992; Morrison et al., 2000). Modern hospitals have been likened to large intensive care units, with very few low-dependency patients (McKenna, 1998). With these changes the patient cared for on the medical ward in the new millennium has been likened to the 'intensive care patient' of five years ago (Brusman-Zaidel, 2000).

In an environment of change, where there is an increased throughput of patients and decreasing resources, there are claims that nurses are expected to do more with less (Jackson et al., 2001). In the context of budgetary constraints they are expected to maintain their skills, learn new techniques and incorporate relevant concepts, theories and principles, as well as integrate new technology into their every-day practices (Barr & Sines, 1996; Morrison et al., 2000; Donner & Wheeler, 2001; McNeese-Smith, 2001). Indeed the integration of complex technology is now seen as an extension of the ward nurses' ability to provide care (Pelletier et al., 2000). In this changing environment a number of researchers argue that the reality is nurses are expected to accommodate increasing levels of patient acuity, maintain their clinical knowledge, and integrate new technology into their daily practice without any increase in resources such as access or availability to further education or increased staffing levels (Buiser, 2000; Morrison et al., 2000).

Staffing levels are increasingly seen as a key issue in the provision of care, and difficulties with recruitment and retention of ward nurses in the context of nursing shortages in acute care hospitals have been reported (Ventura, 1999; Pelletier et al., 2000). Indeed, the level of nurse–to–patient staffing ratios remains a controversial issue (Pilcher & Odell, 2000) with numerous researchers debating the issue of how to effectively introduce an appropriate nursing hours per patient day model (Shindul-Rothschild et al., 2003). The importance of getting it right is highlighted in research

conducted by Aiken et al. (2002, p. 1993). They report that 'nurses in hospitals with the highest patient–to–nurse ratios are more than twice as likely to experience job related burnout and almost twice as likely to be dissatisfied with their jobs compared to nurses in the hospitals with the lowest ratios'.

These findings are supported by claims that nurses' job satisfaction is being undermined by pressures from increased workloads and fewer staff (Chard, 2000; Morrison et al., 2000). Not surprisingly, a 1995 report commissioned by the NSW Health Department found that there was a 'depth of bitterness and disenchantment' amongst nurses and that 'low staff morale and poor self esteem appeared to be endemic' (Wilmore, 1997, p. 17). These findings clearly support the widely held contention that the restructuring of health care services and the concurrent decrease in nursing resources is directly linked to a disgruntled nursing workforce. It may be as Aiken et al., (2002) argue: restructuring initiatives with the intent of increasing efficiency results in discontented nurses. The combination of all of the above factors has increased the pressure on 'bedside' registered nurses (Ventura, 1999) and if we are not careful, Ludwig (1998, p.185) warns, 'we can easily be depleted of the one valuable resource our consumers need—caring'.

The general nurse

The terms 'multi-talented' (Patterson, 1995), 'well-diversified' (Castledine, 1996) or 'multi-focused' (Maclaine, 1998) have been used to conjure up images of the general nurse. The general nurse is required to sustain a wide focus in practice (Maclaine 1998), while generalist knowledge is credited with providing a foundation for nursing practice. Indeed, Castledine (1997a) argues that the central place of the general nurse is apparent in the focus of undergraduate programs which prepare nurses for what is, in reality, generalist practice. He also contends that it is around 'the general domain that all practice revolves and relates' (Castledine, 1996, p. 1146). This is not surprising given that general nurses are expected to both possess and utilize an extensive range of skills as well as having the capacity to respond to a broad spectrum of common health and

illness problems. The capacity to provide care, 'is based on the nurse's knowledge and skills' (Roman, 2001, p. 80), such that well developed assessment skills and an ability to detect subtle differences is not dependant on the use of technology (Meyer, 1992). Whilst it is acknowledged that general nurses are the largest, most visible group in the hospital setting (Tummers et al., 2001) it is interesting to note that however, few studies focus on areas of concern from the perspective of nurses who choose to work as general ward nurses within the hospital environment (Chard, 2000; Tummers et al., 2001).

Recent studies involving the general nurse include a comparison of the positive and negative work attitudes of home health care and hospital nurses (Simmons et al., 2001), a comparative study of work characteristics and reactions between general and mental health nurses (Tummers et al., 2001), and a comparative study of bedside nurses and charge nurses (Chaboyer et al., 2001a). Consistent with the findings of Aiken et al., (2002), these studies illustrate that perceived stress, increased workloads, emotional exhaustion, worker conflict and negative perceptions about general nurses exist and contribute to the dissatisfaction they feel. However it is interesting to note that within the literature there is a primary emphasis on comparing general nurses to specialist nurses, rather than exploring the role of general nurses and their issues and concerns in a contemporary health care context. What is well recognized, however, is that a focus of the general nurse is the provision of 'care'.

Caring

Caring has been described as the core of nursing; its very essence (Stevens & Crouch, 1995; Stevens & Crouch, 1998). However, having a focus on the provision of care has implications for general nurses as caring work is largely misunderstood and devalued, being 'unappreciated [and] largely invisible' (Henderson, 2001, p. 130). In many respects this is not surprising because while nurses can articulate how they interact, care for and assist patients, this private discourse is not apparent in the documentation of nursing care, nor discussed in professional forums (Bjornsdottir, 1999). For example, a study carried out by Bjornsdottir (1999) reported that while nurses were clearly able to describe and document the public work of nursing—that is; the tasks, treatments and

regimes— the private work 'behind the screens' (Lawler, 1991), while informally acknowledged, was not documented. Similarly, Colliere (1986, p. 102) argues that the lack of acknowledgement of the nurse's role in providing care reflects a perception that 'care' perse is a 'taken-for-granted' aspect of nursing and as such is considered 'unworthy', requiring 'lower skills' and 'scanty knowledge', because it is associated with the 'invisible work done by invisible women'. In some respects this is ironic, for as Farrell (2001, p. 29) argues 'it is [the provision of] care that nurses can, perhaps, legitimately claim to have expertise'.

Reflective of the status afforded to caring, 'bedside nursing', 'ward nursing' and 'general nursing' are terms used interchangeably. The focus on care means the work of the general nurse is often referred to as menial, repetitive, boring, basic, just general nursing care, low level and housework (Herdman, 1998). The historically caring focus of general ward nurses certainly has implications for their status, for as Short (1995, p. 312) observes:

> The nursing profession in general has never recognized, or rewarded, those clinical nurses who choose to stay at the 'ward level'. They are regarded either as lacking in direction, ambition and initiative or as being too rigid and unable to adapt to the new progressive thinking.

However an alternate view also emerges from the literature. For example, Hyziak (1995, p. iii) in her PhD studies, investigated nurses' attitudes to nursing work and reported that 'older nurses were significantly more satisfied with basic care tasks, interpersonal tasks, and leadership tasks than were younger nurses'. Interestingly she found that night nurses were significantly more satisfied with basic care tasks than were nurses assigned to the day shift. Similarly, Castledine (1997b) argues that while many nursing tasks may appear boring and repetitive, when a patient is unwell 'feeding and toileting, although appearing simple and menial, can often mean more to a patient than any of the sophisticated and technical procedures'. Likewise Lawler (1991) argues, the label 'basic nursing care' denigrates the physical body and nursing. It is interesting to

note that despite the fact that 'caring' and 'basic' have been identified as fundamental aspects of nursing activities, they are lacking in status and prestige. Rather, it is technical specialist nursing that attracts prestige and status (Stevens & Crouch, 1998).

How then are general medical ward nurses regarded?

Much of the work of general medical nurses is focused on the provision of care to the elderly—since they constitute the majority of patients cared for on medical wards. According to the Australian Institute of Health and Welfare (2001-2002, p. 122), 'the population group 65 years and over accounted for a high proportion of admitted patients' for both private and public hospitals. In part, this profile compounds the lack of status associated with general medical nursing. As numerous researchers note, caring for the aged is often perceived by both graduate and student nurses as custodial, unchallenging and unrewarding—generally the more 'basic' the work, the lower its status (Stevens & Crouch, 1995; Herdman, 1998; Happell, 1999b).

Similarly, in a study of student nurse career preferences conducted by Happell (1999c) general medical/surgical nursing ranked number six out of eight areas of practice, with only 6.7% of student nurses choosing general medical or surgical nursing as their first preference. The least popular areas were psychiatric nursing, which was ranked at number seven, followed by the significantly less popular nursing home work. Invariably students and recent graduates prefer working with children or in technologically demanding areas (Stevens & Dulhunty, 1992). Student nurses do not envisage a future career for themselves on a general medical ward caring predominantly for the elderly patient. Rather, there is evidence that prior to graduation students are already focused on which specialty they should pursue. Indeed there is a significant body of literature which outlines student preference for specialist career paths (Stevens & Crouch, 1995; Herdman, 1998; Happell, 1999a), reflecting a growing interest in specialization. Moreover, student nurses are said to be swayed by the perceived value of youth over age and the perceived importance of technology at the expense of the more 'basic' or 'fundamental' nursing care (Stevens & Dulhunty, 1992; Stevens & Crouch, 1998).

Status and prestige

As is obvious in the preceding discussion, the concepts of status and prestige are not generally associated with the role of the general medical ward nurse. Rather, prestige is more often associated with advanced or specialist roles, in nursing management and academia, and is linked to higher education rather than to the practical care reflected in bedside nursing care (Johnson & Cook -Bowman, 1997; Bradshaw, 1998). It is important to note that devaluation of worth and professional expertise, lack of status, low self-esteem, hierarchical subordination and passivity are recognized as characteristics of oppressed group behaviour which has been well documented in the nursing literature (Roberts, 1997; Scarry, 1999; Roberts, 2000; Farrell, 2001; Lee & Saeed, 2001). Differing educational levels within the nursing profession, according to Johnson and Cook-Bowman (1997, p. 203) 'result in intraoccupational hierarchies within nursing and prestige ambiguity'. This shapes nursing hierarchies such that the role of the general ward nurse attracts very low levels of occupational prestige as it is widely devalued, which in turn diminishes the job satisfaction of those who undertake the role. As Porter (1992, p. 721) argues, the 'lowly position' of these clinical nurses encourages those who wish to gain autonomy in nursing practice to seek the alternative route of moving up the nursing hierarchy in order to gain a position of status. This is reflected in moves to shift the provision of 'care', traditionally the domain of the general nurse, to the unlicensed care worker or extended-care assistant who have at best limited training.

The relative lack of status afforded to caring work is reflected in recent developments which has seen many hospitals recruiting extended-care assistants to provide clinical support (Carney-Badovinac et al., 1999). However, personnel who lack standards of competency and accountability for patient care (Solecki, 1998) have the potential to compromise patient care (Buiser, 2000) and may often be unsafe (Scarry 1999). Whilst cheaper to employ, many researchers believe that the quality of health care is threatened by utilizing extended-care assistants (Solecki, 1998; Bradshaw, 1999; Buiser, 2000), who are taking over what was previously thought of as hands-on nursing work

(Bradshaw, 1999). Comforting, chatting, holding hands, feeding, washing, bathing—the fundamental aspects of nursing care that have previously been described as the very 'essence of nursing'—are being handed over to unlicensed personnel (Solecki, 1998). Registered nurses find this problematic, as a study by Solecki (1998) found that registered nurses were concerned about the care patients were receiving from extended-care assistants recognizing that it devalued their work.

It is ironic that the acuity and intensity of care of hospitalized patients is greater than ever before, but fewer general nurses are allocated to provide this care (Gilliand, 1997). On one hand the extended-care assistant is providing the more fundamental aspects of nursing care, and on the other, the nurse specialist is providing a more specialized focus (Bradshaw, 1999). This mode of care brings with it 'concerns related to a disuniting effect on the discipline of nursing and a fragmentation of nursing's traditional generalist practice' (Fairweather & Gardner, 2000, p. 26).

A discussion of this topic is augmented by making mention of the similarities between perceptions of the generalist nurse and those of the General Medical Practitioner. Interestingly, General Medical Practice has been described as 'just a collection of applied specialties tinged with a hint of sentimentality' (Mansfield, 1991, p. 29). While General Practitioners (GPs) have been described as marginalized and declining in status (Petchey, 1995), working 'on the boundary between the clinical manifestations and the idiosyncratic life of the patient' (Marinker in Mansfield, 1991, p. 30). Like nursing students, few medical students choose general practice as a career option, as hospitals appear to be the dominant centre point of medicine (Gray, 1992). Comments such as 'ending up in general practice' and 'just a GP' perpetuate the marginalized position of the General Practitioner within the medical community (Strasser, 1991, p. 611). This parallel discourse illuminates the plight of the marginalized worker and highlights the need for further research into the role and perceptions of being 'just a nurse'.

Conclusion

The nursing workforce of the new century is forecast to be driven by an increasing demand for and a decreasing supply of registered nurses (McNeese-Smith & Nazarey, 2001). Increasing patient acuity, economic downsizing, intraoccupational hierarchy and prestige and the introduction of nurse specialization and extended-care assistants has impacted on the role of the general medical ward nurse. Fundamental nursing care, which traditionally has been the core focus of the general ward nurse, has become unattractive, mundane and 'devalued by those who seek to make a nurse into an autonomous and above all academic professional' (Bradshaw, 1999, p. 447). At present it would seem that there are major issues concerning the devaluation of care and consequently care providers (Colliere, 1986). Perhaps it is timely to explicate and investigate the issues surrounding general ward nurses' perceptions of their practice and of themselves. This in turn may further illustrate the value of general ward nursing, demonstrating to others that fundamental nursing care is the foundation of nursing practice, irrespective of setting. Happell (1999a, p. 505) clearly supports this view, implying that:

> the nursing profession must seek to actively portray the equal importance of all aspects of nursing care and to deter the situation where certain aspects of practice are considered more important and/or more desirable than others.

Tregoning (1995, p. 145), further argues that 'nurses who are doing the everyday work of nursing need to begin to value themselves and the work they do'. There is however, a paucity of research which explicates the characteristics and attributes of registered nurses who are doing this 'everyday work'. The implication is that the conduct of further research into the issues and concerns of the general ward nurse is imperative, particularly in a climate where recruitment and retention of registered nurses 'at the more basic grades' (Bradshaw, 1999, p.447) is a major issue in Australia and indeed globally. Hence this study will explore the question: **What are the key issues and concerns that general medical nurses, working in an acute hospital, identify as**

impacting on their practice? In order to address this question, an appropriate methodology was identified and this will be discussed in the following chapter.

CHAPTER 3 - METHODOLOGY

As a traveller who has once been from home is wiser than he who has never left his own doorstep, so a knowledge of one other culture should sharpen our ability to scrutinize more steadily, to appreciate lovingly, our own (Mead, 1992).

Introduction

As is evident from the literature, today's nurse on a general medical ward faces many challenges. Increasing economic pressure within hospital settings, combined with greater workload demands in a progressively more complex environment has frustrated many nurses. It was a concern with these issues that provided an impetus for this study. I wanted to tease out and delve into the intricacies pertaining to the nursing practice of registered nurses who work within a general medical ward environment. Given the relative lack of information this area I was intent on employing a methodology which would allow me to explore the issues and concerns that impacted on the practice of general medical nurses.

Approaches to research in nursing

As is the case with other disciplines, the primary purpose of nursing research is to generate and validate knowledge needed to inform practice (Polit & Tatano-Beck, 2004). Traditionally the focus of nursing research has been informed by the logical positivist philosophy, with a focus on 'describing, explaining, predicting and controlling from a reductionistic perspective' (Wilson-Thomas, 1995, p. 569). Traditional (positivist) approaches to research in nursing place particular emphasis on behaviour that can be observed directly. Positivists argue that factors such as meanings, feelings and purposes are not particularly important, as they can be misleading (Haralambos et al, 1996, p. 17). The positivists' emphasis is on quantifiable data, or data that involves the measurement of observations and the assignment of numbers to values and variables

combined with the utilisation of numeric manipulation (statistics). This data can be generated by surveys, content analysis or from the analysis of existing data. However this research approach has insisted on separating the mind, body and external environment and does not place personal experience at the centre of the research process (Wilson-Thomas, 1995; Cormack, 2000). Indeed the dominance of logical positivist research as applied to nursing has been subject to some critique. As DePoy, et al. (1999, p. 563) suggest, this approach 'does not capture the uniqueness, diversity and complexities of some practice issues [in nursing]'.

Within nursing there has been a growing concern with the appropriateness of quantitative research methods to investigate human behaviours which cannot be isolated and quantified (Wilson-Thomas, 1995; Cormack, 2000). This has led to a growing interest in qualitative methods which sit more comfortably with the focus in nursing, on the interactions of persons within their environment (Campbell & Bunting, 1991; Cormack, 2000). The shift towards qualitative research in nursing places nurses' experiences at the centre of the research agenda. Such experiences cannot be captured by the traditional positivist approach as 'nursing as a discipline, has the distinct knowledge base which stems from the lived experience of nurses....[who are] involved in caring relationships with their clients' (Cormack, 2000, p. 150). However it is important to note that in a male-dominated society with a tradition of positivist science, qualitative research methods are seen as unscientific or soft, focusing on humanistic qualities rather than research-based practice (Meyer, 1992). In light of this statement, Cormack (2000) suggests that different research methods need not compete: what we need to understand is how each research approach can assist us to better understand our nursing practice.

Choosing a method

In this study I was interested in gaining an understanding of the issues and concerns general medical nurses identified as impacting on their practice. This was appropriate because, as outlined in the previous chapter, little work has been done in this area.

Adopting a qualitative approach was important because in the words of Lawler (2002, p. 7) I wished to examine 'the more personal, idiosyncratic and human aspects [of nursing practice] that may not be easily measured in the scientific sense'. However, considering the historically oppressed situation of nurses (Roberts, 1983) I was keen to use a method that situated the nurses as participants, rather than merely 'subjects for study'. Following Wilson-Thomas (1995) and Cormack (2000) I wanted to give the participants in the project the opportunity to be actively involved in the research process. Given this interest it seemed plausible to consider critical research as the method of choice for my master's thesis, as doing research for and with people rather than on people is at the very core of this approach (Polit & Tatano-Beck, 2004). This was important because my experience working on a general medical ward demonstrated that nurses had little status within the hospital hierarchy—a situation subsequently reinforced in my review of the literature. Given this I did not want to further disempower these nurses through their participation in this research. Rather, the intent was to open up opportunities for them not only to explore the issues that shaped their practice but also to develop new insights and understanding into those issues. Hence, the decision to use a critical method in this study.

Critical research methods

Critical research provides a process where practice issues can be investigated in relation to the context in which they occur. Specifically, this approach to research is 'useful when nurses need to not only understand a particular situation—but do something about it' (Street, 1992, p. 51). As will be seen in the discussion that follows, a key interest of critical research is to foster empowering processes among research participants. It is especially valuable in circumstances where participants share a common concern and a desire to investigate, critique and make choices to improve or challenge their work practices (Street, 1992; Browne, 2000). Given the relative lack of status and recognition afforded to general medical nurses (Porter, 1992), such concerns were of interest to this study. However, in order to understand critical research it is first necessary to explore the historical and theoretical interests which have informed critical methods;

specifically, critical theory.

Critical theory: Origins and theoretical underpinnings

The term 'critical theory' is associated with the diverse body of work that emerged out of the Frankfurt Institute of Social Research. This institute (also known as the Frankfurt School), was a privately funded organization that was established at the University of Frankfurt in Germany in 1923 by a group of left-wing intellectuals (Crozier, 1991). The school was comprised of philosophers, sociologists, psychologists, economists, political scientists and lawyers. The overarching goal of the group was to analyse social change in the 20th century while continuing to develop the work of Karl Marx (Haralambos et al., 1996). However members of the Frankfurt school also sought to integrate the work of other theorists such as Freud and Hegel which distinguishes these so-called Western Marxists from their Soviet counterparts. Scholars at the Frankfurt School believed that a revision of this traditional/orthodox Marxism of the Soviet's was necessary in order for it to be more relevant to the 20th century (Wilson-Thomas, 1995; Manias and Street, 1999). These scholars targeted the technological knowledge being developed by logical positivistic science and its contribution to the oppression of the working class whereby people uncritically accepted their situations (Campbell & Bunting, 1991; DePoy et al., 1999). They wanted to acknowledge and integrate subjective forms of knowledge into traditional Marxism so that perceptions and experiences of human beings, as well as objective observations, would be considered as having scientific worth (Campbell & Bunting, 1991; Smith, 1997).

As a result of this intellectual imperative, the group developed to encompass a critique of culture under the leadership of Max Horkheimer (Wilson-Thomas, 1995). However these scholars continued to challenge the dominance of positivism and sought to understand human experience as a means of changing the world (DePoy et al., 1999). As the Nazis gained power in Germany in 1934, the school lost its momentum. At this time the Institute's circumstances became bound up in political and social change: most of the School's theorists were Jewish and Marxists and therefore they relocated to New

York (Crozier, 1991). Here they further developed their notions of power and justice 'particularly in response to the hegemony of positivism in the United States' (DePoy et al., 1999). Following the Second World War, some of the original scholars returned to Europe, however it was not until the 1960s that a 'second generation of German theorists' continued the development of critical theory (or conflict theory as it is often termed in sociological literature) under the influence of Jurgen Habermas (Stevens, 1989)

Critical theory is described by Habermas (in Wilson-Thomas, 1995, p. 573) as 'a means of generating knowledge that is based upon free, uncoerced, undistorted communication'. Critical theory is said to reveal a potential to improve or transform situations by 'explicating ways of knowing, emphasizing the value of persons, histories and lived experiences, respecting diverse realities' (Wilson-Thomas, 1995, p. 574). Such interests resonate with Marx's notion of the consciousness of people arising out of their daily existence and not out of the realm of ideas that are somehow independent of the material world; a contention widely held in the German philosophy of the time (Turner, 1991). As Turner (1991) further notes, Marx believed that people produce their ideas and conceptions of the world in light of the social structures in which they are born, are raised and live.

Therefore, critical theorists argue that culture and social meaning must be interpreted within a historical context: in other words, knowledge is not objective but rather is socially constructed (Smith, 1997). As observed by Alderson (1998), critical theory does not see society as a well functioning organism; rather as a collection of competitive factions that are struggling to attain power and access finite resources. Critical theorists hold that within the struggle for power and resources, some interests dominate. As such, there is an assumption that dominant political, economic and social structures are so embedded in society and are so routine that their omnipresence renders them almost inaccessible to every day consciousness (Dickerson & Campbell-Heider, 1994). It is argued that the covert nature of these forces of power allows them to maintain and reproduce their dominance, as they remain unchallenged by those whom they dominate.

While some groups may actually benefit from this, it largely serves to restrict or oppress others. Anthony Gramsci who was influenced by Marx described this power relationship as 'Hegemony' and did so in terms of the 'state' or 'ruling class' maintaining control of the rest of society by gaining the approval and consent of that society (Haralambos et al., 1996). Hegemony referred to the achievement of political stability; not through the use of force, but by persuading the population to accept the political and moral values of the ruling class (Haralambos et al., 1996). It is an interest in the effects and operation of power relations that is a key concern of critical research methods.

The interests of critical research methods

A core interest of critical research methods is to actively encourage individuals to question the taken-for-granted beliefs that serve to oppress certain groups and potentially liberating them from the conscious and unconscious constraints that interfere with social interaction (Dickerson Campbell-Heider, 1994; Wilson-Thomas, 1995). Dominant ideologies, that is, 'belief systems that a society, group or class presents and treats as fact' (Crotty, 1998, p. 157), influence how power structures are created in society. By questioning, critiquing or studying the dominant ideologies in a society from a historical context, and exposing how these ideologies serve to dominate and oppress certain groups, critical researchers aim to expose hidden power relations and enhance individual autonomy and responsibility of research participants (Campbell & Bunting, 1991; Dickerson & Campbell-Heider, 1994, Wilson-Thomas, 1995). Thus, in the context of this study, questioning the status quo of medical ward nursing may uncover the taken-for-granted nursing practices and in the process reveal hegemonic power relations. It is within these situations that Taylor (1995, p. 145) encourages nurses to identify the factors which may serve to oppress them, so that they might then have the freedom to 'give the kinds of nursing care that they might ideally give'. From a critical standpoint, explaining and questioning the social order serves 'as a catalyst for enlightenment, empowerment and emancipation' (Browne, 2000, p. 39).

The imperative to promote enlightenment or to raise the consciousness of research

participants is a core interest of critical researchers. The intent is to open up the opportunity for participants to develop new understandings of their situation (Manias & Street, 1999). Through this process they can challenge taken-for-granted understandings that work to oppress people and limit them from reaching their potential (Henderson, 1994; Street, 1995;). This in turn opens up the possibility of challenging hegemonic power relations (Manias and Street, 1999) as they come to a new recognition of 'the social, political, economic and personal constraints on freedom' (Henderson, 1995). For nurses, this is especially important because participation in critical research processes gives them the opportunity to explore how they are disempowered within the dominant structures of health care—which situates others as having greater expertise (Cheek & Rudge, 1994).

At the same time it is important to acknowledge that merely developing new understandings does not lead to liberation (Humphries, 1997, p. 5). In acknowledgement of this, critical research methods have a key interest in promoting empowerment among the research participants (Lather, 1991). Here empowerment relates to a concern with, as Lather (1991, p. 4) contends, 'analysing ideas about the cause of powerlessness, recognising systematic oppressive forces, and acting both individually and collectively to change the conditions of our lives'. At the same time it is important to recognise that, empowerment is not something that is done for you, rather it is a process which is undertaken by you (Lather 1991). Further, Martin (1997, p. 3) suggests:

> empowerment refers to peoples' access to resources which increase their capacity as individuals and groups to take greater control of decisions at personal and community levels, so they might challenge relationships and structures of power.

In this way, critical researchers aim to empower people through their participation in critical research processes and thereby bring about change. Indeed Crooks and Davies (1998) argue that critical researchers function as the agents of change, where their collaborative research projects act as the vehicle through which transformation is enacted. In this study then, the aim is to give a group of general medical nurses the

opportunity to develop new insights which may open up the possibility of their imagining a future somewhat different from the past.

Following on from and intricately linked to concerns with provoking enlightenment and empowerment, a key interest of critical research methods is to promote an emancipatory agenda. Henderson (1995, p. 64) defines emancipation as 'the state of being in which people come to know who they are and have the collective power to determine the direction of their existence'. The intent of this study is to facilitate a process whereby the participants move from identifying possibilities for change to imagining possibilities for transformative action. Manias & Street (1999) describe this process as emancipatory because it involves a shift from understanding to action. At the same time it is important to acknowledge that within the context of a very small study like this, the opportunities to bring about empowerment, emancipation and change are extremely limited.

Limitations of the critical agenda

While critical research methods hold out great hope for disadvantaged and oppressed groups to achieve some level of liberation, it is also important to acknowledge the limitations with this critical agenda. Of note, while empowerment is a central construct in critical research methods, it is difficult to deny that this term also carries with it connotations of the powerful outsiders attempting to empower the marginalized oppressed (Bowes, 1996). This is a tension inherent in critical approaches to research which endeavour to expose power relations that perpetuate oppressive behaviour (Street, 1992). This means that critical researchers must always be alert to the potential of further disempowering the research participants. Little wonder, that Opie (in Bowes, 1996, p. 4) warns us that 'empowerment to do what the researcher wants, not empowerment of the researched' is always a cause for concern in this method.

Similarly, it is interesting to note that grandiose claims of critical researchers relating to enlightenment, empowerment and emancipation have been challenged (Manias & Street, 1999). Indeed, post modern theorists critique 'the politics of emancipation' (Lather, 1991, p. 4), and challenge the notion 'that any research process will enable us

to find a true or right answer of choose a correct course of action' (Street, 1995a, p. 51). In recognition of the provisionality of any claims for improvement, this study can be considered to have at best a critical intent. That is—the aim is to open up opportunities for the research participants to reconsider their understandings of their situation and challenge taken-for-granted ways of being general medical nurses.

Strategies of critical research

Critical research employs an array of strategies to facilitate a critical agenda. A key focus is to create opportunities for the development of a dialogical discourse. Henderson (1995, p. 51) describes negotiation, reciprocity, critical self- reflection and collaboration as providing the basis for developing a 'dialogical discourse', emphasizing a 'mutuality of experience' and democratic participation between the researched and the researcher. In the context of the critical research process this involves the researcher and research participants in a very different relationship to that assumed within the traditional interview process. Rather than being the passive respondents in the research where the researcher is in control of the situation (Martin, 1997), the focus is on developing reciprocal and collaborative interactions between the researcher and the research participants (Lather, 1991). Throughout this process research questions emerge from the priorities raised by the participants, who are 'active subjects' rather than 'passive objects' (Martin, 1997, p. 3).

The development of reciprocity is a key to facilitating a critical discourse (Campbell & Bunting, 1991). Reciprocity involves give-and-take and the 'mutual negotiation of meaning and power between the researcher and the participants' (Lather, 1991:57). In this study, this involves the research participants having access to all data and having the opportunity to make comment on and discuss my analysis of the issues raised. This involved the conduct of critical dialogues with each participant, which involved a sharing of experiences. In this I did not function as the objective interviewer, rather as a collaborator in the fleshing out of issues and ideas. This was important not only to facilitate reciprocity but also promote critical reflection on the issues raised. Through critical reflection, participants are encouraged to examine taken-for-granted rules, habits

and traditions, foster a capacity to uncover hidden meanings, challenge traditional beliefs over come their problems and eliminate their frustrations (Meyer, 1992; Wilson-Thomas, 1995).

In order to enhance reciprocity and the opportunities for critical reflection within the study, following the completion of the critical dialogues and the conduct of thematic analysis of the issues raised, I returned my analysis to the participants in the form of a discussion paper. We subsequently met in a discussion group to consider the findings. Having access to the discussion paper promoted a collaborative agenda, because in the discussion group the participants had an opportunity to critically reflect on the issues raised and collaborate in developing new insights and understanding of their situation as general medical nurses. This involved a process where the researcher and participants 'negotiate and decide together on meanings' (Campbell & Bunting, 1991, p. 5). In this study, the process of collaboration and collaborative theorizing (Lather, 1991), came to fruition following the distribution of the above-mentioned discussion paper. In effect, the group discussion provided an environment in which all participants were able to reflect on and clarify issues pertaining to their nursing practice. According to Jamieson & Mosel-Williams (2003, p. 271), this opens up the possibility of 'gaining authentic, quality data by using the candour and spontaneity of participants in an atmosphere of dynamic group interaction'.

The critical intent of the discussion group allowed me to engage in a dialogue with the participants that challenged their views and encouraged them to confront their own attitudes to their work, thereby promoting critical reflection on the issues raised. The aim of this meeting was to validate, contest, expand meaning and critically reflect on the participant's role as a general medical nurse. As Babbie (1998, p. 249) suggests, 'the dynamics which occur in discussion groups frequently bring out aspects of the topic that would not have been anticipated by the researcher and would not have emerged from interviews with individuals'. In this way, within the group, new insights and understandings of the issues and concerns that shape general medical nursing practice emerged.

Establishing validity

Critical research assumes a different position with respect to validity when compared to that of traditional positivist approaches. As Lather (1991) argues, in critical research projects such as this study, we need to look at trustworthiness and reconceptualise validity in terms of face validity, construct validity and catalytic validity.

In terms of face validity, Lather notes that this form of validity is operationalised by recycling to the research participants 'description, emerging analysis and conclusions' (1991, p. 67). The participants recognition of the validity of the data is evident when they experience what Street (1992, p. 144) describes as a 'click of recognition'. In the context of this study, face validity was achieved through the process of giving back to the participants an analysis of the issues in the form of a discussion paper. The participants were provided with an opportunity to discuss, clarify, extend and critique my interpretation of their comments. Face validity was achieved when the participants reported that the analysis accurately reflected their views. This was most evident in Sophie's response to the discussion paper, when she said *'finally someone is going to put out there all that we do, that gives me a good feeling'.*

Construct validity is associated with the degree to with the theorisations developed as part of the research are not solely an artefact of the researcher. According to Lather (1991, p. 62), in order to achieve construct validity, it is important for the theoretical constructs developed by the researchers to be subject to the scrutiny of the participants, in what she describes as a process of 'systematised reflexivity'. The key concern is the degree to which the participants' understandings and experiences are reflected in the analysis developed by the researcher. In the context of this study, construct validity was achieved through a process of collaborative theorising where the participants and myself negotiated and decided together on meanings related to the issues raised. In this sense it is closely related to face validity as the participants validated my analysis of the data by indicating that it accurately represented their position.

Catalytic validity is concerned with assessing the emancipatory effects of the research (Lather, 1991). That is—the degree to which the research participants develop their understanding as a consequence of participation in the critical research process. In a sense, achieving catalytic validity provides a measure of the effectiveness of the research. In this study catalytic validity is evidenced by the participants developing new understandings and insights with regard to their practice as general medical nurses. For example, as will be seen in the next chapter, this was particularly evident in the language they used to describe elderly patients nursed on the wards, and their understanding of the barriers which seemingly prevent them from providing high quality nursing care.

A final measure of the veracity of the data is assessed through its credibility. Credibility 'refers to confidence in the truth of the data or interpretations of them' (Polit & Tatano-Beck, 2004). This was achieved through having a deep understanding of the context in which the research took place. Through my previous employment as a nurse in this environment and the collegial relationships with participants of the study, I had greater access to insider knowledge (Stringer & Genat, 2004). To enhance the credibility of this study, as outlined above, all participants were provided with opportunities to discuss and clarify my interpretation of their words, thus ensuring an accurate analysis of the issues raised. This clarification process also allowed for participant debriefing in the context of the above mentioned discussion group, which according to Stringer & Genat (2004, p. 51) 'has the purpose of challenging aspects of the inquiry which might otherwise remain only implicit'.

Research design

Research time frame

The research was undertaken in the period February 2002 to November 2003.

Research context

The nurses involved in this study were in practice on two 32 bed medical wards in a regional public hospital. Male and female patients ranging from adolescent to elderly—with a variety of medical conditions including, cardiac, renal, endocrine, respiratory and neurological—are accommodated on these wards.

Participants

Participants were selected from the above general medical wards located in a regional public hospital. Access to these participants was facilitated by my own professional experience as a registered nurse and clinical teacher working in these two areas. Specifics of participants' qualifications and experience were defined during recruitment, the details of which follow.

Recruitment

Following a consultation process with two Clinical Nurse Managers I was invited to meet the nursing staff on the wards to provide all nurses present with information regarding my proposed research and to seek participants. An information sheet (see Appendix 1) was distributed to each of the wards. As a result of these discussions a number of nurses displayed interest in participating in the study.

The requirements of participation included:

- At least three years postgraduate experience.
- Employment on the ward for more than one year. It was envisaged that nurses with this level of experience would have an understanding of the role of the general medical nurse and would be well able to articulate issues and concerns surrounding their nursing practice.

- No gender issues were anticipated because at the time of recruitment, only female nurses were employed on these two wards.

Five nurses subsequently volunteered to participate.

Research process

The critical research methodology was utilized in this study. It involved three stages.

a) Stage One: Critical dialogues

Following the receipt of the ethics approval (see Appendix 4), the first stage of the research commenced. This involved me meeting with each participant to conduct a critical dialogue. The individual 'critical dialogues' were conducted at a mutually agreeable time and place, and in the first instance all participants signed a consent form (see Appendix 2), which enabled them to participate in the study. All dialogues were conducted between the months of July and September of 2002 and were approximately 90 minutes in length. The critical dialogues were semi-structured in format, and each participant was given an opportunity to engage in discussion about their general medical nursing practice. With the consent of each participant the individual dialogues were audio taped and transcribed for analysis. Transcription was conducted by an administrative assistant. Following the guidelines provided by Wellard & McKenna (2001), I provided the administrative assistant with a brief overview of the research project and highlighted the need for confidentiality. Throughout the transcription the typist was instructed to record pauses, gaps and expression. Each participant received a copy of the transcript to ensure validity and accuracy and to encourage critical reflection on the issues raised.

b) Stage Two: Discussion paper

Following the completion of all interviews the data was analysed for themes related to the issues which shaped the participants practice as general medical nurses, which were then documented and presented in the form of a discussion paper (see Appendix 3). This

discussion paper was given to each participant prior to the commencement of the group discussion in stage three.

c) Stage Three: Group discussion

The third stage of this study involved a group discussion. Three weeks after the participants received a copy of the discussion paper, four of the five met as a group. As the participants were allocated to day, evening or night shifts, organising convenient and appropriate times for the conduct of the individual critical dialogues and the group discussion was at times challenging for both the group members and me. Hence, one participant was unable to attend the group discussion

Consistent with the methodology the group discussion gave the participants an opportunity for group discourse (Fulton, 1997) to discuss key issues, concepts and themes which were outlined in the discussion paper. With their permission the group discussion was audio taped and transcribed. As with the individual dialogues this audio taped focus group discussion was listened to carefully whilst re-reading the transcribed data to ensure quality of transcription. This data was analysed in conjunction with the notes I had taken during the focus group discussion. The data collected from the group discussion was analysed in terms of themes and issues concerning their practice as general medical nurses with a focus on identifying new insights and understandings.

The research findings are presented in this thesis. Each participant will receive a copy of the completed thesis.

Personal/professional journal

Consistent with the critical research methodology I kept a professional journal throughout this research process. This required a degree of self-discipline, for which I am now most grateful. This journal was a useful tool for recording critical incidents during the research process, and was 'used for introspection and analysis, thus becoming a tool for personal and professional growth' (Stuart, 2000, p. 111).

Limitations

This research project was subject to a number of limiting factors. Within the context of this Masters project I was governed by University semesters and completion dates; therefore I only met with the participants on two occasions, consequently my ability to invoke a critical agenda was limited—Hence the claim that this study pursued a critical intent.

Because the study is small and uses a qualitative approach it is not possible to generalise from the findings. However, as Street (1995, p. 51) argues, although 'critical research is not able to be generalized [the research] uncovers issues which may be generalized to others in similar situations'.

Collecting data from both the individual critical dialogues and group discussion provided me with an array of information: what was not captured however, was the tension and visible angst as staff from two general medical wards came together. Robinson (1991) concurs, noting that capturing all the meaning, intent and expression when reading the transcribed text is difficult. It is therefore reasonable to assume that some meaning was lost through the process of transcription.

Benefits of the study

a) Participants

This study offered five registered nurses the opportunity to critically engage with issues surrounding their work practices. They were given a 'safe space' to reflect on and tease out specific issues of choice. In doing so it was hoped that the participants could identify and articulate their desire to practice as general medical nurses in an ever-changing and increasingly complex environment.

b) Nursing profession

It is hoped that the findings generated from this study will offer the nursing community a better understanding of some of the issues that are of concern for nurses working

within a general medical ward setting. Highlighting the day-to-day realities of nurses who practice at the bedside will offer insight into the many barriers which prevent these nurses from providing what they perceive to be adequate patient care.

Ethical considerations

The participants were given an 'information sheet', (see Appendix 1) and signed a 'statement of informed consent' (see Appendix 2) prior to the commencement of the study. Discussions between participants were confidential; however anonymity of the participants was not maintained within the group due to the discussion group format. Pseudonyms of the participant's choice were used throughout the transcripts and in the final thesis. Pseudonyms used for this study were Jenni, Sophie, Julie and Jane. Audiotapes and transcripts were secured throughout the research process and the security was maintained as outlined in the ethics proposal (see Appendix 4). The participants were also aware of their right to withdraw from the study at any time without penalty or prejudice.

CHAPTER 4 - DATA ANALYSIS

> *Qualitative analysis—a process of fitting data together, of making the invisible obvious, of linking and attributing consequences and antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence (Morse & Field, 1995).*

Introduction

This chapter explores the issues and themes which emerged from individual dialogues and one focus group discussion, conducted with the five participants in the study. All critical dialogues were transcribed and a close examination of the data followed. Stringer and Genat (2004) call this close examination of data a process of 'distillation', whereby the data is scrutinized and categorized in search of a deeper meaning and understanding. I listened repeatedly to the tapes, with transcribed data in hand. Conscious of the non-verbal cues and silences which had been omitted from the transcribed data I wanted to ensure that individual dialogues had been accurately documented, and searched for what Wellard and McKenna (2001, p. 182) call interpolation, 'the insertion of missing words or grammar', which may subsequently change the interpretation of the conversation.

The first section of the data analysis comprises a condensed representation of the discussion paper (see Appendix 3) which, as suggested above, attempted to give clarity to, and provide a deeper level of understanding to the participants, of the issues raised in the individual interviews or hereafter referred to as critical dialogues. It was intended that the discussion paper should provoke the participants and encourage them to reaffirm or challenge the way they felt about their role as general medical ward nurses.

Section One—Issues raised in critical dialogues

Professional satisfaction

The increased complexity of health care and the associated increased demands on medical nurses led some of the participants in the critical dialogues, to describe themselves as multi-talented and multi-skilled. Their accounts suggested that caring for patients with often complex care needs required them to piece together fragments of information to gain a broader perception of a patient and the patient's illness experience. Comments indicated that a depth of experience as a medical nurse allowed the participants to make sound clinical judgments. As Jane recounted, '*because I have been nursing for such a long time, I really am quite good at knowing when people aren't well. ... I bring with me a whole range of skills and experience*'. This view was supported by Julie, who commented:

> *I have found that I have built up an incredible repertoire of knowledge and skills that I don't even realize I've got until I come to a situation. It's totally different and I apply all that knowledge and I can make a decision very quickly, and very confidently. If I can't, I've got the experience to be able to identify and utilize another resource.*

Reflective of the importance of this knowledge base, Jenni suggested that her ability to '*put all of the pieces of the jigsaw together*' is '*what keeps me there*'. Such comments suggested that having these abilities is the source of some professional satisfaction. The participants affirmed their worth as medical nurses because of their ability to successfully manage complex situations.

Analysis of the critical dialogues also revealed that the participants valued the importance of having a sound practice base and a thirst for knowledge. Indeed, comments implied that this quest for knowledge confirms why they chose medical nursing as their area of practice. As Jane recounted, '*it's* [medical nursing] *challenging, stimulating, there's no better place to learn*'.

What makes medical nursing satisfying?

When the participants discussed those aspects of medical nursing that sustained their practice, they all spoke of the diversity, complexity and intricacies involved with the provision of patient care. It was also apparent that they believed that having a high level of competence was important because of the increased demands associated with working on an acute medical ward. All participants spoke about the diversity of patients with regard to their diagnoses and the specific skill level required to provide appropriate nursing care. This was important because, as one participant noted, the diagnoses of the people under her care ranged between *'absolutely anything and everything'*. Given this, all participants argued that it was essential to have a high skill level to work in this area.

Reflective of participant comments, *'absolutely anything'* referred to those patients requiring interventions for acute illness, chronic illness or associated treatments. Also, consistent with the literature (McKenna, 1998; Brusman-Zaidel, 2000) the nurses' accounts indicated that there has been a marked increase in the acuity of patients now nursed on medical wards. Analysis of their transcripts suggests that as medical nurses they are now expected to care for far greater numbers of acutely ill people. It seems many of the patients cared for on medical wards now routinely require 'intensive' nursing that was previously delivered in specialist, high-dependency units such as CCUs or ICUs. For example, Jenni reported that *'we now get patients that used to go to ICU the patients that we would never see until later on in their hospital admission, we now get immediately'*. Julie further suggested that *'it's not uncommon now for someone to have a cardiac arrest and we resuscitate them on the ward and stay on the ward...whereas four to five years ago they would go up to ICU straight away'*.

As stated in the discussions, these patients formed part of a collective group nursed on the ward who had enormous diversity of diagnoses and related co-morbidities. Julie clearly articulated this when she reported that *'most of the patients would have some kind of a chronic medical condition, often concurrent medical conditions together'*.

Throughout the critical dialogues each of the participants made reference to an eclectic

array of patients requiring nursing care on the ward. These included what were termed *'the acute patients'*, *'the chronic patients'* and the *'non-acute patients'*. A reiteration of the types of patients and diagnoses that these groups comprised of follows. The 'acute' group included those patients who had recently had a renal, cardiac or lung transplant; or those with acute renal, cardiac, respiratory or endocrine disease. This 'acute' group also included surgical patients, who for reasons such as bed shortages on the surgical wards were admitted to a medical ward. Surgical patients were also admitted to medical wards following a post-surgical illness episode, such as stroke or a myocardial infarction. According to individual accounts, other acute illnesses included acute confusional states and those patients in the process of withdrawing from alcohol or drugs.

Analysis of the critical dialogues revealed a second group. These were the patients with chronic diseases, who often had concurrent medical problems. As Julie clearly articulated, *'Diabetic patients usually have cardiac disease and perhaps a respiratory disease, with perhaps a UTI, or an infected leg ulcer... that's a general patient'*. Such is the nature of co-morbidity in some patients that they were frequently admitted on the basis of, as Sophie suggested, *'diagnosis for investigation'*. Sophie went on to explain that such a diagnosis meant *'we'll figure it out later'*.

Finally, as was highlighted in the critical dialogues, another group mentioned by all participants were those patients classified as *'non-acute'*. According to Jane, this group represented a high proportion of the patient mix on her ward, and as she noted, these patients were *'more long-term'*. Jane went on to explain, saying *'they might come with an acute illness and then for one reason or another are* [subsequently] *classified non-acute and are therefore waiting for nursing home placement'*.

A number of the participants referred to the phenomenon of elderly patients who were admitted to the medical ward for acute treatment and then remained as in-patients while awaiting placement in a nursing home. This phenomenon seemed to frustrate some of the participants, and this became most apparent when the nurses used language such as,

'old age for investigation', *'bed-sitters'*, *'the dregs'* and *'social admissions'* to describe these elderly patients. Indeed, one of the participants further commented that the increasing numbers of what the literature refers to as 'bed blockers' (Campbell & Howe, 1989; Lowe, 2002), meant that the ward had become a *'real dumping-ground'*. It was a phenomenon exacerbated at Christmas when it was labelled as *'Granny-dumping'* by Jane. It could be argued that the use of such language suggests a specific ageist agenda at work in the hospital, where elderly patients who require minimal interventional treatment are considered as being less worthy of care. It was interesting to note that, despite the 'taken-for-granted' nature of the deprecatory language used to describe these patients, suggestive that their needs were minimal, many of the participants articulated that this older group actually required very complex nursing care. For example, because generally these elderly patients had so many concurrent medical problems, they required comprehensive and detailed discharge plans. In the discussion paper I queried the used of this deprecatory language, and asked the participants to consider how this language reflected the needs of the elderly.

Responsibilities of a medical nurse

Given the diversity and complexity of the patient mix it was not surprising that all participants argued that to be effective as a nurse in this area, one needed to be an experienced practitioner with an extensive knowledge base. This was clearly articulated by Julie when she said:

> *A medical ward nurse is a 'super nurse', has everything under her belt, has to be knowledgeable, has to be able to think very quickly, be perceptive and be able to pick up on little things, to be able to deal with stress, to deal with conflict, to a certain extent be physically fit, because you're running around and lifting and bending and doing quite a lot. You need to be a counsellor, you need to be a social worker, and you need to be a hairdresser and a florist. Being a nurse is not just putting on a white dress and giving someone a shower; there's so much that you need to do...it's becoming more evident that you have to know more and*

more... as to what we need as a nurse on a medical ward, It's probably easier to tell you what we don't need, because there's less of it.

Given the nature of the work and the complexity and diversity of patients nursed on these wards, again it was not surprising that all participants described a broad range of responsibilities associated with the role of a general medical ward nurse. These included clinical management [that is taking a patient load], administrative management, the provision of staff support and leadership, as well as the supervision of students, graduate nurses and new staff. In terms of clinical management, because of each participant's level of expertise, they all stated that on any given shift they inevitably cared for the '*sickest patients*'.

Additionally, all participants made mention of their significant involvement in the resolution of complex family issues. However it was unclear to me how this involvement impacted on their role, and therefore in the discussion paper they were asked to consider this issue.

With regards to the participants' administrative responsibilities, they included being 'in charge' on evening shifts and at weekends. From their comments it seems that being rostered for evening shifts and weekends occurred very frequently. In this capacity they described being responsible for monitoring the status of all the patients on the ward, organizing often complex discharge planning procedures as well as emergency patient transfers, and ensuring adequate staff for oncoming shifts.

In the critical dialogues participants also articulated their responsibilities for the provision of staff support and leadership. The accounts suggest that it was a 'taken-for-granted', that they would assume this responsibility on any given shift, and that this was not always associated with 'being in charge'. Usually this involved taking on the role of a resource person for all staff on the ward and organizing on-going staff development sessions. Finally, all participants argued that because of their high level of knowledge

and experience, their supervisory responsibilities included mentoring new and graduate staff, as well as preceptoring student nurses. The extent of their responsibilities was clearly encapsulated by Jane, who suggested:

> *I am there for all the patients ultimately. I will always have staff coming to ask me questions. I get pulled away to do things, like taking the difficult bloods, just taking ECGs, escorting patients to and from procedures. Ultimately on a medical ward there are a lot of junior staff. So they come up to you on a constant basis asking questions, not sure about assessments, so you end up assessing a lot of other patients in between and just dealing with all the management stuff, like phone calls that other staff can't deal with.*

Competing tensions

As identified in the critical dialogues, all participants explained that their depth of knowledge and level of experience meant that on any one shift they generally were responsible for the patients with the most complex and complicated care needs. However with this knowledge and experience came the added perception that they also had the capacity to take on the extra supervisory, administrative and clinical responsibilities. Interestingly, in their accounts of practice they suggested that in the wider scheme of things, the latter responsibilities were often unacknowledged. This was cause for concern because analysis of the transcripts revealed that the nurses had to perform a balancing act to meet competing demands. That is, on the one hand they expressed a sense of responsibility to prioritise care associated with the increased acuity of the patients on the ward, ensuring the very sick patients were receiving the care they required. These responsibilities were in conflict with the professional responsibility to provide an adequate standard of care to all patients regardless of their level of acuity and need for acute nursing care. To make matters worse, according to the participants, this conflict was cast within the context of their escalating levels of responsibility. This was associated with increasing numbers of inexperienced staff, ongoing budgetary

restraints which limited the numbers of available staff to care for patients, and a need to adequately care for those patients who had been allocated personally to the participants on any given shift.

The tensions associated with their responsibilities had many implications. For example, a number of the participants commented that they were unhappy, and that this was related to the constant pressure *'to get the job done'*. They argued that this was in part a consequence of the dominant imperative to prioritize the provision of technical care over body care and personal care. In this sense, their comments highlighted a strong sense that they felt caught between the role of nurse as carer and nurse as technician. This became evident when Sophie suggested:

> *We can't provide the nursing care that we want to provide and should be providing, because we are so busy. We are dealing with so many issues. They're* [the patients] *not getting the hands-on nursing care or the time that they feel they deserve and they're unhappy. You can tell that they are unhappy, we don't get as many chocolates now and thank-you letters. There are a lot of complaints put in about the ward. It's not targeted at the nursing staff or saying a nurse is bad or* [has] *done anything bad; it's due to lack of care and that's simply because of staffing levels.*

Analysis of the critical dialogues indicated that managing this tension often meant that the patient was *'juggled'* between the caring role and the need to fulfil the more technical aspects of patient management. Participant comments indicated that in response they experienced guilt as they struggled to prioritize the body care against the technical care. Most of the participants articulated this tension as an everyday aspect of their lives as medical nurses. It was a reality of practice. Their struggle to manage this tension seemingly challenged their identity as nurses. The participants also suggested that like the nurses, many patients on the ward were unhappy because the nurses were unable to meet their care needs. Participant comments suggested that many patients *'missed out'* on care they required because of the *'busyness of the ward'* and the

dominant aforementioned medical–technical imperatives. Indeed, Jenni suggested that it was generally the less acute patients who *'miss out'*. She claimed:

> *Often the elderly who have dementia don't get the level of care that they require on an acute ward, no-one seems to have the time...they don't get the care that they deserve...we have to prioritise and that prioritising is becoming more finely split to the point where patients who have fundamental needs and often those needs involved are issues of dignity, have to be left, to look after the acute patient.*

However, in the context of a busy ward with patients who have highly diverse needs, on occasions it appeared that the *'acute'* patients also *'missed out'* on receiving nursing care. Julie argued this, commenting:

> *Unfortunately on the ward you will have a situation where you will have someone who is being rather disruptive or potentially dangerous and you need to settle that patient down or quieten that patient down and unfortunately there are more acute patients that require a lot of assessment and management during the course of the shift, these patients will miss out* [on nursing care]*...which I don't think is fair but it's just the nature of the ward.*

Comments such as these suggested that the way in which care—either technical care or body care—is prioritised on the medical wards, meant that the patients inevitably *'missed out'* on the care they require. It seems that managing this tension is what caused the participants a great deal of angst—it's a balancing act.

According to most of the participants, changes in patient acuity have also impacted on the way they focused their nursing care. At this point in the discussion paper I encouraged the participant to reflect on what it means to be too busy to fulfil those aspects of nursing care that they see as pivotal to their nursing practice. The outcome of

this reflection will be discussed in Section Two of this chapter in the sub-section titled 'the busy nurse.'

Status and prestige

Consistent with the literature (Porter, 1992; Johnson & Cook -Bowman, 1997; Bradshaw, 1998), analysis of the transcripts further revealed that nurses working on the acute medical wards experienced a lack of recognition and status. This left them feeling devalued, frustrated, unhappy, and tired. A key issue identified in all conversations was the participants' sense that being devalued was in part related to the types of patients they cared for who were generally elderly, low-status clients. Participant comments indicated that these patients were afforded a low status because of the perception among their nursing colleagues that they required little more than body care, and little in the way of medical treatments and interventions. Indeed, Julie commented that '*I think that people would say that you're there* [as a medical nurse] *doing the big heavy sponges and the showering and the toileting and the hauling into bed.'* In part there is an element of truth in this perception, as all participants recounted going home from work very tired because of the often physical nature of their nursing. However, Julie clearly articulated that the lack of appreciation of the complexity also associated with medical nursing was in part a consequence of the work of medical nurses largely being '*totally invisible and unacknowledged'*. The issue of status was highlighted by Sophie when she alluded to the dominant interpretation of medical ward nursing as constructed by 'surgical nurses'. She claimed that:

> *The surgical nurses see our work as being very easy and boring, when in fact they don't really understand that we certainly have the acuity that they have. They think of us as a lower form of nursing because we deal with all of the full nursing-care patients and the nursing-home patients...they see us as at the bottom of the ladder.*

It was interesting to note that some of the participants commented that in their

experience, student nurses also construed medical nursing as menial and uninteresting. As Jenni stated, '*they see it as less exciting...almost like a nursing home*' .The above comments suggested that working on a medical ward was considered not as prestigious or as high in status in the scheme of things. Jane made this point when she said:

> *There definitely seems to be more prestige along with "I'm an ICU nurse," or "I'm an ER nurse". Where if you're a medical nurse, you might have a specialty on the ward, but you don't call yourself a renal nurse or a cardiac nurse...you're just a nurse...you're just a general medical nurse.*

This language suggested the operation of a hierarchy within nursing, with those nurses who may be perceived by their colleagues as performing primarily body care—the medical nurses—being situated at the lower end of the scale. Further indicative of their status, many of the participants also expressed concerns that they felt devalued by their 'nursing managers'. This became apparent when the issue of staff-to-patient ratios was raised by the participants. For example, most participants argued that whilst the surgical wards of the hospital were adequately staffed with regard to patient acuity, this was not so on the medical wards. Indeed, as one of them noted:

> *I'm constantly frustrated...particularly when you talk to people working on the surgical side...they say we've got 30 patients and 8 nursing staff, and we're* [on the medical ward] *struggling with 6* [nursing staff] *and 32 patients. So that makes you quite frustrated and very bitter because it's the whole hierarchy.*

Reflective of the apparent lack of status associated with medical nursing within the hierarchy of care, one of the participants further argued that you have to '*fight*' for extra staff, when staffing levels are low, '*because of the budget*'. These and other statements suggest that they believe that medical wards are discriminated against with respect to resources and it is evident that they perceive consequent budgetary constraints as a practice reality. In the discussion paper I encouraged the participants to critically reflect

on the apparent lack of status afforded to medical ward nurses, and to consider how this might impact on the team ethic.

Taking the 'team' out of team-work

Throughout all of my conversations with the nurses another key issue emerged as a source of their unhappiness. Analysis of the critical dialogues highlighted that all participants held the desire to be a part of a 'team'. However, further analysis revealed that within the context of the problems outlined in this paper there was a lack of team ethic on the medical wards, and this was strongly associated with a diminished interest in continuing to work in the field of nursing.

Reflective of participants' concerns with the team ethic, their descriptions also highlighted the lack of collegiality indeed, as one of them recounted '*you can walk onto a ward and there can be a sense of gregariousness, people are talking and chatting and laughing. That's not always authentic. That comes at the expense of genuine collegiality'*. It is apparent from this narrative fragment that there was a degree of superficiality between colleagues and this superficiality impacted on their nursing practice. Such comments reflect Street's (1995b, p. 30) notion of the 'tyranny of niceness' where nurses act in artificial ways to maintain a façade to fit the stereotype of 'nice' 'caring' people. In the discussion paper, I examined the 'team' in nursing. I asked the participants to reflect on the notion of teamwork, what makes for an effective team, and if the team was unhappy then who ultimately suffered.

I concluded the discussion paper by reiterating that it was a provisional analysis of the issues and themes arising from individual critical dialogues. I acknowledged the need to be heard and the need to have a voice as a medical nurse with Jane's closing comment, *'Too many of us view ourselves as "oh I'm just a nurse; just one of the girls", we don't really articulate our needs; we're ashamed of saying that we want to be acknowledged'.* The arrangements for the group discussion were discussed and the participants thanked for their continued commitment to the research process.

Section Two – Analysis of the group dialogue

> *Thus men [sic] begin to single out elements from their background awareness and to reflect upon them. These elements begin to stand out assuming the character of the problem and therefore a challenge. Men respond to the challenge directed at negating and overcoming, rather than passively accepting, the 'given'. As critical perception is embodied in action, a climate of hope and confidence develops which leads men [sic] to attempt to overcome the limit-situations (Freire, 1972, p.56).*

Following the interviews all group members were presented with a thematic analysis of issues raised during individual discussions. This paper was titled, 'The story so far: a discussion paper' (see Appendix 3).

The purpose of sharing this paper with all participants was to encourage each person to critically reflect on the issues raised and to seek further clarification and comment with regard to their experiences and insights as general medical ward nurses. This was important because 'giving back' data to the participants in this kind of study is an intrinsic part of the critical process (Lather, 1991). However, following the distribution of the issues paper I became very apprehensive, and was I anxious that the paper did not reflect their views. I was also concerned that I may have offended or misinterpreted them. To my surprise, prior to meeting in our group, three of the five participants telephoned me with positive responses. As I recorded in my journal, Sophie searched the paper looking for *'her voice'* while Jenni stated, *'it was good to see how I went'*. It was apparent that they had read the document with keen interest. However, despite this, it was with trepidation that I organized the focus group discussion as I was unsure of how the nurses from two different wards would react to each other.

Organizing the discussion with two groups of nurses from two wards was logistically challenging. As recognized in the literature, attempting to get five nurses who

predominately worked full-time shift-work into the same room at the same time, was difficult (Robinson, 1995). After much negotiation, a date was set when four of the five nurses were able to attend. When we finally met, initially the atmosphere was tense and the participants strategically placed themselves so the respective members of the two wards sat opposite each other, as if in preparation for battle: arms folded; tense, rigid sitting positions; grimacing.

Given the atmosphere, it was not surprising that the discussion was slow to start. However I adopted a strategy to create deliberate opportunities for each participant to contribute to the discussion. Throughout the meeting I intermittently used specific prompting questions related to the themes previously highlighted in the issues paper. As the discussion progressed the participants spoke of their experiences and suggested that the analysis in the issues paper very accurately reflected their position, as general medical ward nurses. Reading the paper had a powerful effect, as Julie stated, *'We all know what we said, but to actually read it on paper I think has a bit more of an impact'.*

Of particular significance to all participants was how reading the paper broke down the sense of isolation they experienced. For example, Julie's first comment clearly demonstrated the importance, for her, of analysing the key issues raised in the paper when she explained; *'It's nice to read that what we do on our medical ward happens on other medical wards; it doesn't make you feel so isolated.'* The notion of feeling isolated was a central issue identified by all participants, however as this comment suggests, acknowledging the experiences of others encouraged the nurses to critically explore their sense of isolation. It became apparent in the first instance, each participant viewed herself as being somewhat disconnected. This was primarily due to lack of prior opportunities for these nurses to explore the professional issues surrounding their practice. For example, Jane commented; '*I expected that people felt the same way that I did, but* [previously] *there was never a space to talk about my feelings*'. As a consequence, reading the paper and taking the chance to consider their situations, they developed a new appreciation of their common experiences and a sense of community quickly emerged within the group.

Consistent with these developments and the methodological intent of the study, the participants increasingly engaged in a dialogue which had a collaborative intent (Lather, 1991). In the discussion the perspectives of all group members were shared, and the issues raised were interrogated. Within thirty minutes of the discussion commencing I no longer assumed a key role in prompting or leading the group. Rather, participant interaction was spontaneous, vigorous and interesting and the discussion continued for almost four hours. It was apparent, these nurses relished the opportunity to voice their thoughts and opinions in what was considered by Jane to be a *'safe space'*. Throughout this time they engaged in a passionate analysis of the topics raised in the issues paper. For me this was most rewarding as previously I had strong doubts as to the importance of my research, and questioned whether others would find it interesting or of benefit to nurses or nursing. Clearly my concerns were allayed. I wrote in my journal, following the group discussion, 'what was most remarkable was their sense of amazement that rather than being adversaries they shared so much'.

It was clear that the discussion paper had caused the nurses to critically reflect on the issues they had raised. Comments such as, '*You've hit the nail on the head, finally someone is going to put out there what we actually do'* not only validated the analysis but demonstrated the importance, to the participants, of revealing aspects of their nursing practice that they believed were concealed. There was a sense of release, where formerly unacknowledged aspects of practice were made explicit. One such facet was the deprecating language used to describe elderly patients within the acute care arena, suggestive of an ageist agenda.

Institutionalised ageism

Reflecting on the issues raised in the discussion paper, all participants spoke of the language they used to describe the elderly patients they cared for. Specifically, they responded to my question posed in the discussion paper—how well does the language used to describe these patients reflect their needs? In answer to this question the nurses acknowledged that this language served to diminish the value of the elderly because it

labelled them in terms of the level of care required—for example, *'low care', 'low skill'* or *'low maintenance'*—rather than acknowledging them as people with complex needs. According to all participants, once the elderly have been labelled using these descriptors their complex care needs associated with multiple co-morbidities are trivialized. Unfortunately, according to Jane, '*because of the language that we use to depict these elderly patients their care needs are often invalidated.*' As a result the nurses acknowledged that these elderly patients were automatically scaled at the lower end of the nursing-hours per patient-day workload model, rather than being looked at individually in terms of direct and indirect nursing care required. This was inappropriate, according to Sophie who said:

> *The fact that if they are classed as a nursing home-type placement patient, well that alone should let you know that they* [the patient] *are requiring a high level of care; they can't care for themselves, they've got to go into a home; so one would assume that a good level of time needs to be allocated to that patient.*

During the discussion the nurses shared many examples of a perceived inappropriate patient categorization scheme and its subsequent implications for older patients. As explained in the literature, patient categorization schemes endeavour to calculate nursing hours required per patient-day (Shindul-Rothschild et al., 2003). According to Jane, the application of the patient categorization system suggests that *'in the acute care arena, nursing home-type patients just need a wash and then you put them in the chair for the rest of the day and they're Okay'.* What it doesn't allow for, according to other participants, is the complex level of care required by these vulnerable, elderly patients who often have a countless health care issues.

Critically reflecting on this issue, the group members realized that this kind of categorization was inappropriate as it dealt with nursing home-type patients as a homogenous group. Inevitably, this resulted in a diminished perception of these patient's complex array of individual needs. Furthermore, Jane suggested that the current model used to calculate nursing hours per patient per day—coupled with the

depersonalizing language used to depict patients who are waiting for nursing home placement—'*straight away decreases these elderly people to nothingness*'.

Through these discussions, the group members came to a new understanding of the ageist agendas at work in their practice and the way that the taken-for-granted descriptions of elderly patients supported these agendas. Reflective of the critical intent of this study, exploration of the above issue provoked the group to explore possible reasons for the use of such language. A clear link became apparent between what the group called '*complex family issues*' and '*societal issues*'.

Complex family issues

As the discussion pertaining to care of the elderly within an acute medical ward unfolded, so did the notion of blaming families for lack of care afforded to their elderly relatives. Following the distribution of the discussion paper, participants were asked to define *'complex family issues'*. As evidenced in the discussion paper, during the individual critical dialogues, complex family issues significantly impacted on time constraints of the registered nurse within the medical ward environment. In the group discussion, participants explained that complex family issues is used as an umbrella term to generalize family concerns related to patients, which result in significant resource implications for the nurses' time. The nurses explained that complex family issues and concerns primarily centred on locating appropriate accommodation and nursing care for elderly relatives following discharge. According to most participants, this inevitably resulted in *'a lot of behind the scenes phone calls, family conferences and paperwork'*. Moreover, Jane believed that there was an expectation from relatives *'that you will fix everything,* while Julie suggested that once an elderly patient is admitted to the ward *'the onus* [of care provision] *has moved from the relatives to the hospital to provide ongoing care for the patient'*. She continued '*they* [the family] *expect that you will wave a magic wand and fix everything in life'*. According to the participants, some family members are not prepared to care for their elderly relatives at home because they [the family] are '*too busy*'.

Indeed there was general agreement within the group that the responsibility of caring for elders has shifted from the family to the State. However, critically reflecting on this issue, the nurses shifted from a position of blaming families for making unreasonable demands on their time and resources, to understanding this phenomenon within a broader socio-political framework. In the discussion the nurses were able to identify global issues which impacted on the changing nature of the family. That is, the shift from the extended to the nuclear family, particularly in Western cultures. It was apparent that as a result of their dialogue a new position emerged wherein the nurses acknowledged the way that changing social arrangements contributed to their situation. Indeed, as Julie suggested:

> *It's very cultural, and it's obviously the way that society is, and it's reflective on the ward, because we know that a large number of our patients now are awaiting nursing home placement, rather than being cared for by family members at home. And a lot of them* [patients] *don't actually require a high degree of physical care, but they will stay with us until they go into a nursing home, and it is sad that obviously society's focus has changed. And it is now not on the family to be the carers for their elders.*

Despite these new insights, throughout the conversation regarding complex family issues a sense of frustration prevailed within the group because, as Sophie indicated, dealing with these issues was *'often totally unmanageable"*. At a local level these issues had impacted on their ability as medical nurses to provide appropriate care for the aged in an acute-care environment.

An important underlying issue permeating the preceding discussions was that of increased workload. In addition to caring for elderly patients, and the subsequent paperwork burdens associated with caring for patients awaiting nursing home placement, the participants reported an increased number of patients with complex needs being cared for at ward level.

Workload

The participants reached a consensus that as medical nurses they had experienced an increased workload on the wards, especially over the past five years. This perception was noted in the discussion paper where participants spoke of patients '*missing out*' on care due to competing workplace demands. These were demands associated with the increasing number of managerial tasks, accountability in terms of documentation, and the higher level of acuity of patients. In the discussion paper the group members were asked to reflect and comment on this significant issue. During the focus group discussion, the group members reflected critically on how they felt when patients '*missed out on care*'. There was an abiding sense of dissatisfaction with their role as medical nurses because, as Julie suggested '*I'll leave there* [the ward] *a lot more often feeling dissatisfied than feeling satisfied for what I've actually achieved during a shift...I always feel that I could have done more* [for the patients]'.

Subtly woven through the focus group discussion were stories of increased workload associated with budgetary constraints resulting in inappropriate staffing levels, which in turn compromised the nurses' ability to provide appropriate patient care. Whilst the issue of budgetary constraints in hospitals was briefly mentioned in the discussion paper, in the focus group the participants explored the implications these constraints had on their daily practice as nurses. They reported that the staffing levels in their wards were insufficient to provide effective patient care.

Of particular concern for these nurses was that insufficient staffing levels often meant that patients sometimes died alone. This was of great concern to all participants. These nurses expressed feelings of *'sadness', 'guilt'* and *'devastation'* when they walked into a room and found that a patient they were caring for had died alone. This, according to Jane, was the *'most awful consequence of missing out* [on nursing care]'. All group members claimed they were frustrated with the continual compromising of high-level patient care for which they [the nurses] were educated. Reflective of the critical intent of this research, exploration of the above issue enabled these nurses to understand and interpret their increasing levels of dissatisfaction related to their perceived inability to

deliver what they consider to be quality nursing care.

The busy nurse

Following the above discussion all participants commented on the issue of managing *'competing tensions'* as raised in the issues paper. The issues paper raised concerns with what was called *'a balancing act'*. The articulation of this concept caused these nurses to critically reflect on their workplace practices and subsequently comment on the concept of *'busyness'*. In the process they explored the issue of *'not being able to sit down'*. They explained that sitting was invariably equated to being *'lazy'*, *'slack'*, and *'catching up with gossip'* or *'not doing any work'*. These sentiments created a significant dilemma for each participant because, as they argued, nursing activities which are not perceived as 'being busy', such as telephone conversations, liaising with other staff members, or completing complex patient discharge documentation, were not considered legitimate or important nursing work.

Part of the problem appeared to relate to the way these activities took the nurse away from the provision of direct patient care. However, when they were unable to complete the tasks within the specified timeframe they experienced what they termed *'imposed guilt'*. That is, being made to feel guilty by their colleagues for not completing all allocated direct patient care needs in a given timeframe. As Jenni argued:

> *we 'pay lip service' to the fact that nursing has moved on, when in fact ti hasn't. They say on our ward that nursing is a 24-hour-a-day job, and that care needs will be met in that time. However there is this underlying tone that if you haven't washed all of your patients on an early shift, or you haven't done all of the dressings, then what have you been doing all day.*

Julie further highlighted the impact of this issue claiming:

> *You could be in with someone who is sick and dying and because you haven't washed your other patients, or you haven't completed all of your notes or discharge documentation then* [you can be

made to feel] *'I'm not a good nurse and I'm lazy and I haven't done anything'. I know that I'm providing the utmost care and managing my time appropriately; the stupid thing is that I actually feel bad if I sit down for five minutes and talk to someone.*

Julie went on to articulate the absurdity of the situation: *'I have to justify to my colleagues on the next shift why being with a dying person was more important than washing someone or writing notes. That's unreal!*

This was an especially pertinent issue for these senior nurses who, as outlined in the discussion paper, had significant administrative responsibilities and usually were caring for *'the sickest patients'*. According to Jenni, *'every day is a busy day, we all know that, it's just that, well, I might plan and prioritize my day differently to yours, the outcome is still the same, but I don't want to have to justify it all of the time'*. Their attempts to deal with having to justify fundamental patient care decisions seemed to undermine their sense of selves as nurses. However, following further reflection, the participants recognized that they too had been guilty of perpetuating the value associated with appearing 'busy'. It was apparent even that these nurses, with years of experience, supported this agenda in order to be valued by their peers. Nevertheless, with the opportunity to discuss and critically reflect on this issue a different perspective emerged as Julie argued when she said:

> *too many of us do what we're told. Traditionally that's what we had to do, rather than thinking, 'hey hang on a minute, we can change that'. I mean we can change, it just comes by someone saying well look, I don't think that's appropriate and this is another option.*

The group acknowledged the context of the real world of medical ward nursing and suggested that bringing about change would be difficult. Nevertheless, they also

believed that having an opportunity to reflect on and reconsider the issues associated with the cultural imperatives that support and value the 'busy' nurse was, in the first instance, a start. In this way, they exposed how hegemonic power relations worked to ensure conformity to the belief that, a good nurse is a busy nurse.

Relationships with nursing colleagues

An underlying theme filtering through the preceding discussion was unsatisfactory collegial relations. In each of the individual dialogues the lack of peer support was noted. Consequently in the discussion paper the participants were asked to consider the perceived lack of team ethic in their environments, prior to meeting in the group. As a result a plethora of comments emerged in the group discussion; the nurses explored this issue and its implications for ward staff. Sophie stated, *'the ward for me is not a supportive environment'*, whilst Julie claimed, *'if I could go back to a ward where everyone talked to each other that would be good'*. Interestingly, Jenni reported, *'you want to feel that you can trust your colleagues and you need to respect each other and there is no respect on the ward, we don't actually respect the people we work with and for'*. This discussion indicted the absence of support and cohesion in the work place environment and has contributed to some of the participants feeling devalued and undermined. Furthermore, given the lack of acknowledgement of the significant role played by medical ward nurses; this lack of collegial relations within the ward compounded a pervasive sense of powerlessness. This became evident when Sophie suggested, *'The only people that know what you do are your peers in that environment, and if they're devaluing you and if they're saying things about you, then obviously where does that leave you...that actually renders you totally helpless'*. What became apparent was that this sense of powerlessness had immobilized these nurses and prevented them from advocating for themselves. In contrast to this point Jenni suggested, *'It's ironical because we do stand up for our patients and we stand up for their rights, but when it comes to each other, I mean it doesn't happen'*.

Intricately linked to the nurses' sense of dissatisfaction with a lack of collegiality amongst nursing staff on the ward was concern related to their nurse managers. All

group members noted an expressed perception of being unsupported by management. As indicated in the discussion paper, most group members felt devalued by their nursing managers. However, in the context of the group discussion the participants took the opportunity to criticize their nurse managers for their unwillingness to address nurse workload issues in light of fiscal constraints. During this discussion many of the participants claimed that they were *'frustrated'* with and *'forgotten'* by nurse management. Managers were portrayed as being consumed by budgetary issues rather than patient care. However, critically reflecting on this issue, the group identified the changing nature of the role and function of the nurse manager as a possible cause of this dilemma.

All of the participants noted the changing nature of the role that was once one of 'Charge Nurse'. This position was retitled Clinical Nurse Consultant in the 1980s; however these nurses are now known as Clinical Nurse Managers. Jane believes that this is an apt description because *'the ward manager now primarily looks at managing the ward as opposed to being there as a support person for the staff'*. According to the participants, this restructuring initiative has alienated nurse managers from their clinical staff. As Sophie aptly suggests:

> *Clinical Nurse Managers have no expectations whatsoever to perform any clinical duties on the ward, it's purely managerial and what is very, very evident is that this is what is causing a big split between the ward staff and their manager, because they're completely removed from each other.*

What this suggests is an undermining of relationships and cohesion within the nursing team. The perceived conflicting objectives of both parties lead these clinical nurses to criticize their nurse managers in the first instance. There was little doubt however, that the prime issue of concern was of maintaining clinical standards because, according to Jane, *'gone are the days where you could ask your Clinical Nurse Consultant for advice and assistance; it's now the other way around'*. Furthermore, Jenni claimed, the nurse manager can *'become very reliant on me for clinical information about all of the*

patients on the ward'. Accessing clinical expertise to ensure good patient outcomes was a major concern for the participants. The need for another level of support—clinical education—was identified as essential to boost staff morale and ensure patient safety. However according to Jane:

> *there is no next level, you're here caring for these very complex patients and often you require additional knowledge and skill, and we have no immediate resource person; the manager comes to tell you to hurry up because you'll mess up everyone's morning tea-break because you're late, but what you want is clinical support!*

Addressing this contentious issue enabled these nurses to debate and tease out reasons for the noted division between nurse managers and '*bed-side nurses'*. In this sense, from participants' comments it appeared that the apparent difference in focus between the two groups is the issue; that is, financial issues as opposed to patient care issues. Whilst many possible solutions were suggested, it was interesting to note that although these nurses had criticisms of their nurse managers they were also very aware of the pressures and competing tensions endured by Clinical Nurse Managers. Jane finished this conversation stating, '*I would never want her* [Clinical Nurse Manager] *job*'.

Throughout this conversation the participants were able to make sense of the growing divide between themselves and their nurse managers. Not surprisingly, during this process the participants' criticisms of others led to concern about their own patterns of behaviour, because as Jane carefully stated, *'its always easier to blame others for our situation, but when you sit back and think about it we are all on the same side trying to provide the best outcomes for the patients'*.

Conclusion

It was the experience of the participants that with the increasing economic pressure placed on the hospital and rising consumer expectations, not surprisingly an increased level of staff dissatisfaction, frustration, resentment and apathy had occurred.

Unrealistic workloads and clinical restructuring initiatives have led to disharmony between ward nurses and nurse managers, primarily due to the conflicting objectives of both parties—economic imperatives versus patient care. Perhaps more than anything else, lack of peer support has at times rendered these nurses helpless. However, in spite of these identified issues, a discovery process occurred for the participants during the research group discussions.

Not only did the group members develop new insights, but they were able to acknowledge, in a safe place, the context of the real world of medical ward nursing. There was a sense of belonging and understanding between all group members. Julie aptly stated *'I haven't heard any swearwords; what I have heard is passionate discussions...what we do have is integrity and commitment and we've got a good reputation'*. The group members concluded that the present work conditions were not conducive to job satisfaction and effective patient care; however, they felt that change must come from within. Jane ended the discussion by stating:

> *So many people these days think about themselves and they forget about the patient; they forget about working in a supportive, nurturing, kind environment; so they just go there, feed themselves, do what they think is right; they're just so isolated, and they don't work as part of a team and then they go home...that's it...it's that notion of what you were talking about—camaraderie, collegiality, that stuff that has tended to slip—and we need to get that back, collectively as a group of nurses caring for people...we're all doing the same work, fundamentally we're all caring for patients.*

CHAPTER 5 - DISCUSSION OF RESEARCH FINDINGS

This study examines the experiences of nurses who work in general medical ward settings and highlights a number of issues which need to be considered. The findings indicate that on the one hand the participants derive enormous satisfaction from their work as general medical nurses on the wards. However, on the other hand, they also indicate that their capacity to realize their potential as nurses is undermined because of a range of political and contextual constraints.

It is apparent that, as is the case in other hospitals in Australia, the nurses involved in this study work with increasing numbers of elderly patients who have multiple co-morbidities and require complex nursing care (Australian Institute of Health and Welfare, 1999; Department of Health and Aged Care, 2000; Department of Human Services, 2001; Australian Institute of Health and Welfare, 2001-2002; Department of Education Science and Training, 2002). The demographic profile of the nurses suggests that they are highly committed individuals. On average they have worked in the general medical environment for 11 years. In terms of understanding why they stayed in general medical nursing for such a long period, in the context of endemic problems with recruitment and retention of nurses (Armstrong, 2001; Jackson et al., 2001; Joint Commission on Accreditation of Healthcare Organisations, 2002), the research indicates that nurses find providing hands-on nursing care in a complex environment stimulating, and appreciated the opportunity to develop meaningful relationships with their patients. The significance of contact with patients is reflected in the literature which indicates that nurses value 'hands-on' nursing work (Bradshaw, 1999). Such an interest reflects a central concern in nursing with the provision of care (Williams, 1998; McNeese-Smith, 1999; Newman & Maylor, 2002).

While the nurses expressed a long-standing appreciation of nursing and the benefits associated with being a general medical nurse, the findings of this study suggest that their situation is somewhat fraught. Their accounts—shared in the context of this project—indicate that in general these nurses feel alienated, isolated and dissatisfied

with their work. Comments such as, *I leave there* [the ward] *a lot more often feeling dissatisfied than feeling satisfied for what I've done during a shift....I always feel that I could have done more* [for the patient] clearly indicate a sense of disaffection. These sentiments reflect what appears to be a growing trend within nursing which sees nurses becoming increasingly unhappy with their lot (Meadows et al., 2000; Aiken et al., 2001). However, while the literature provides a broad account of this issue, the findings of this study are valuable because they provide detailed insights into the experiences of general medical nurses.

In terms of understanding their sense of disillusionment, the findings suggest a critical issue relates to the perception that these highly experienced nurses receive little acknowledgement of the complexity of knowledge and skill required to be a general medical nurse. They see themselves situated low down within what the literature identifies as the increasingly specialized hierarchy of care within nursing (Miller, 1995; Bousfield, 1997; Bradshaw, 1999; Fairweather & Gardner, 2000). That they express a sense of disaffection at this situation is in some ways not surprising given that general ward nursing is recognized as the backbone of contemporary nursing practice (Roman, 2001). In part it can be argued that these nurses are experiencing an unacknowledged effect of the increasing shift to specialization which undermines their sense of worth as acute-care nurses. Their comments indicate that this hierarchy, while well accepted within medicine (Bullough, 1990), has negative implications for nurses wanting to stay 'at the bedside'. If these nurses are representative, which I would argue they are, then it seems that in a contemporary Australia we have an experienced pool of clinicians who derive little satisfaction from their work and feel that their capacity to function as nurses is undermined. In these circumstances it is hardly surprising that the recruitment and retention problems continue (Department of Human Services, 2001).

Compounding these issues is the increasing busyness of the contemporary health care context. The literature documents an increase in throughputs associated with decreased lengths of stay, increase in acuity of patients in hospital, and greater administrative burdens placed on staff (Department of Human Services, 2001; Joint Commission on

Accreditation of Healthcare Organisations, 2002). Associated problems with the adequacy of instruments used to calculate appropriate nurse–patient ratios have also been identified (Pilcher & Odell, 2000; Department of Education Science and Training, 2002; Shindul-Rothschild et al., 2003), leading to concerns that the provision of patient care will be compromised. As such, it is not surprising that the nurses in this study raised concerns about their increased workload demands with sicker patients, requiring more complex care, as well as concerns associated with a higher percentage of inexperienced staff. According to the nurses, on their wards, despite the increasing acuity of patients, there has not been a concomitant rise in the number of experienced registered nurses to provide care.

When given the opportunity to consider the issue in the context of the group, they quite rightly questioned the adequacy of nurse-to-patient ratios on the wards and associated these problems with the use of archaic instruments to calculate patient dependency. According to the nurses, these calculations are based on the numbers of registered nurses per patient without taking into account nurses' level of experience. In this regard the findings of this study support concerns raised in the literature that in a rapidly changing health context, there are problems with appropriately resourcing the provision of nursing care (Pilcher & Odell, 2000; Aiken et al., 2002).

Interestingly, also, their analysis indicates a concern with an ageist agenda underpinning the situation, given that the majority of people nursed in this context are elderly. They rightly question whether the fact that the patient population is elderly—and as the literature demonstrates, often construed as 'bed blockers' (Campbell & Howe, 1989; Lowe, 2002)—is associated with an acceptance of the ongoing under-resourcing of care. It is interesting to note in the individual dialogues that the nurses used ageist language in their descriptions of their elderly patients. However when given the opportunity to revisit these comments in the group discussion, the nurses came to recognize their unwitting complicity in this ageist agenda.

The research participants concerns with their inability to provide care to their patients

represents a dominant theme in this study. This is most evident in their comments relating to finding patients dead in their beds and feeling a sense of despair. It was as if this struck at the very heart of who they were as nurses. If a patient died alone this was almost the worst thing, because surely the dying patient requires priority, rather than isolation. According to the nurses, rather than receiving high quality nursing care, these patients only received what they described as *'the basics'*. For these nurses their sense of inadequacy and discomfort with the situation is palpable. In relation to patients missing out on care, it is apparent that the situation of fewer experienced nurses providing care to greater numbers of acutely ill patients threatens their sense of integrity and identity as nurses. In other words, because caring is fundamental to nursing practice (Stevens & Crouch, 1998), when nurses are denied the capacity to provide care, this undermines their professional identity. According to the literature this is ironic, because nurses in this situation are unable to get on with the work of nursing (Bradshaw, 1999).

Further compromising the nurses' capacity to provide care is what they identify as a dominant interest in meeting budgetary constraints. According to the participants, the focus of the nurse is patient care, not balancing the budget, and as a result there appears to be a growing divide between the nurses at the bedside and their clinical nurse managers. According to the participants in this study, the Clinical Nurse Manager role has been restructured to have a dominant focus of management and budgetary issues. According to the nurses, the shift of the Clinical Nurse Manager focus to that of management denies the ward access to a person who was previously renowned for significant clinical expertise. The participants claimed that they were now seen as the clinical experts and, as such, it is little wonder that, as the most experienced clinicians on the wards, the span of nurses' responsibilities has radically increased. According to the nurses' accounts, this means they have concurrent direct care responsibilities, supervisory responsibilities, and ongoing administrative responsibilities, all of which sit in conflict with each other. The endless administrative, budgetary and technical imperatives have encroached on their time, and prevented them from providing care at the bedside. In effect they are required to maintain their responsibilities for patient care as well as take up a range of activities previously associated with the role of the Clinical

Nurse Manager. This view is certainly supported by the literature which suggests that restructuring in this way undermines the capacity of nurses to carry out the job for which they were educated. (Meadows et al., 2000; Aiken et al., 2001; Aiken et al., 2002). It is of concern that the participants reported going home and worrying about the care they had not been able to deliver. It could be said then that, if you are unable to care, then how can you be a nurse, and more to the point why would you want to be? Not surprisingly there is plenty of evidence to suggest that the inability to provide care of a high quality causes low morale amongst nurses (McKenna, 1995; Seccombe & Smith, 1996).

Another significant frustration reported by these nurses related to an apparent lack of collegial engagement with other nurses on either of the wards. They appeared to yearn for collegial relationships on the wards, only to feel isolated and disengaged. In part, the lack of access to the Clinical Nurse Manager, due to the more prominent administrative function outlined above, appears to compound these problems. Not only is the Clinical Nurse Manager not available to provide clinical expertise, but this also appears to separate her from the 'team'. It is not hard to imagine that if these nurses are so disaffected, their colleagues on the two wards would feel little different. This is of great concern, for as the literature demonstrates the most important factor in job satisfaction is workplace communication patterns and relationships with co-workers (Tovey & Adams, 1999; Jackson et al., 2001).

In conclusion, the findings of this study clearly demonstrate that our status as an island State does not immunize us from the problems which are facing nursing globally. The way the participants expressed themselves is mirrored worldwide. There is little doubt then that hospital cost control initiatives have negatively impacted on the general medical ward nurse. The findings from this study suggest that, within this contemporary health care context, these nurses are often placed in a compromised situation where their capacity to be a nurse is seemingly undermined. What is interesting to note however, is that although the participants were dissatisfied with conditions pertaining to their work, they were committed to attempting to provide a high standard of patient care. In a

climate where research into recruitment and retention of experienced registered nurses is prevalent worldwide, it is notable that little research pertains to nurses who care for patients at the bedside, because in many respects these nurses are the backbone of care provision. It is hoped that the findings of this study will generate interest and provide impetus for further research.

CHAPTER 6 - REFLECTIONS ON A CRITICAL JOURNEY

For years I have been trying to justify my existence as a medical nurse. I remember having to tell people why I chose to work on a medical ward, and not specialize. Working on a general medical ward, for me, has been challenging and stimulating. It gave me the chance to focus on the complexities and intricacies of patient care. Foremost in my mind has been the provision of what some label basic nursing care, however, I like the term fundamental care, because this conjures up thoughts of 'essential', 'vital' or 'important'. When starting this research I was intent on pulling back the sheets, so to speak, to expose general medical nursing and illustrate the very essence of what it means to be a general medical nurse. There followed an intense period of critical reflection, where I concurrently undertook the research and considered my own history as a general medical nurse.

In many respects it is not a happy story. In the very first stages of the project it was evident that there were serious problems on the wards. When I first sought to recruit participants, none came forward. Finally, five registered nurses from two wards volunteered. It appeared that the five nurses were interested in the project, but were too frightened to speak out. In my early discussions I had the distinct impression they were fearful of being reprimanded or chastised for 'speaking out against the system'. A journal entry written at the time recounts my experience with one participant who 'approached me, very warily. She said that she did not want anyone to know that she was going to be a part of the study, it was all very hush-hush'.

Before long I found myself sitting in front of each of the nurses in the 'interview' context. As the interviews unfolded it was clear they were not interviews in the traditional sense, rather, 'critical dialogues'. The importance of promoting collaboration and reciprocity were foremost in my mind. Comments such as *'You've made me think about what I do; I've actually had to reflect on my practice'* affirmed for me the importance of this research and the power of the critical research process to provoke critical reflection. The nurses appeared appreciative and almost grateful for the

opportunity to speak about their nursing practice and to engage in a dialogue with me in which we explored their issues and concerns without fear or favour. It is a phenomenon documented by student researchers in other similar projects (Hill, 1999; Brown, 2001).

Given the sense of threat associated with participation, it was evident that maintaining anonymity was of vital importance. However, the research process required the individual participants to come together as a group. Given the contentious nature of my analysis of the individual dialogues, in the form of the discussion paper, I was extremely anxious at the prospect of the group meeting. When the time arrived, one by one the participants entered the room. The atmosphere was tense as each participant eyed the other up and down. They were clearly not old friends. Reflective of what to me seemed their hostile disposition the staff from each ward positioned themselves opposite each other with arms folded. In the first instance I saw my role as facilitating the group discussion, actively prompting and highlighting issues raised in the discussion paper.. My hope was that, through enacting a dialogic process, the barriers so evident at the start of the meeting would break down. Consistent with the critical intent of the research process, as the nurses began sharing their thoughts and ideas on the issues raised in the discussion paper, the atmosphere was quick to change. As the discussion unfolded the nurses recognized the similarity of their issues and concerns and that they had far more in common than they ever imagined. Within a short space of time they developed a new sense of cohesiveness as a group, passionately discussing and reflecting on the issues raised.

It became apparent that the process of critically reflecting on their practice within a supportive and collaborative environment enabled these nurses to break down feelings of being isolated. At the same time they developed deeper and clearer understandings of the wider social, economic and political agendas governing their nursing practice. This was most evident in the discussions around their use of ageist language in the critical dialogues and how this reflected the wider perceptions about elderly people in our society. That the nurses engaged so enthusiastically with a critical process was more than I had hoped for given my initial intent was to at best expose the reality of the life of

a general medical nurse. Here I found myself in the midst of a critical discussion with a group of nurses who collaborated to critically reflect and develop their analysis and understanding of their situation.

From their discussions and reflections the participants acknowledged the intricacies and complexities involved in the provision of patient care on their wards and vowed never again to call themselves *'just a nurse'*. In this sense it is as Freire (1972, p.108) suggests that, 'for members of an oppressed group to achieve freedom, they must reflect on themselves and their situation, engage in dialogue and take action'. Within the context of this small project the opportunities for action were limited. However, change was evident in the new relationships forged between the participants. Hostility and suspicion were replaced with an emerging sense of collaboration and appreciation of the commonality of their concerns. Clearly the critical research process offers nursing great opportunities. In many respects I was saddened that the project could not continue. According to the nurses, participation in the research was the first time they had been given the opportunity to speak critically about their practice. It was clear that they relished this opportunity and would have appreciated the chance to continue. At the very least they left the group discussion as allies and colleagues who were capable of supporting each other and arguing the case for general medical nurses from a far more informed perspective.

In closing, I refer to a speech given by Theodore Roosevelt, in Paris at the Sorbonne in 1910: capturing the essence of this critical journey,

> *It is not the critic who counts, not the man who points out how the strong man stumbled, or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes short again and again, who knows the great enthusiasms, the great devotions, and spends himself in a worthy cause, who at best knows achievement, and who at worst if he fails at least while daring greatly so that his*

place shall never be with those cold and timid souls who know neither victory nor defeat (Roosevelt, 1910).

CHAPTER 7 - CONCLUSION

The findings of this study indicate that there are many issues which compromise the ability of general medical nurses working on wards in acute hospitals. While this study provides valuable insights into the specific issues and concerns faced by these nurses, more research into this area must be undertaken as a matter of urgency. Clearly, if further research confirms the substance of the findings presented in this small study, the issues identified in this research must have an impact on the ability of health care organisations to recruit and retain nursing staff in what I would argue is the backbone of acute-care health provision. It is imperative to address these concerns if being a nurse in a ward environment is to remain viable. Equally the findings of this study demonstrate the importance of nurses having the opportunity to meet together to discuss and critically reflect on their practice.

The recommendation of this study is for further research to be undertaken with general medical nurses to further explore the issues and concerns which impact on their capacity to provide high quality care to their patients.

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APPENDICES

Appendix 1 – Information sheet

University of Tasmania

Information Sheet

NAME OF THE STUDY

Just a Nurse: How do nurses who work on a general medical ward regard their practice?

RESEARCH QUESTION:

What are the key issues for registered nurses who work on a general medical ward?

CHIEF INVESTIGATOR

Andrew Robinson, Lecturer in Clinical Nursing, University of Tasmanian School of Nursing.

STUDENT INVESTIGATOR

Annette Marlow, Master of Nursing student, Tasmanian School of Nursing, Launceston.

AIMS OF THE STUDY:

- Investigate the experiences of Registered Nurses' and reveal issues that are significant to their nursing practice whilst working as general medical ward nurses.
- Explore the possibilities for Registered Nurses' to develop new insights and understandings which may potentially enhance their nursing practice.
- Promote the motivation and impetus for further research into issues surrounding the practice of nursing.

This study is being undertaken as part of the requirements for a Masters of Nursing Degree.

STUDY PROCEDURES:

This study will involve four registered nurses in an acute medical ward at the Launceston General Hospital. Should you volunteer to participate in this study you will be asked to attend a one hour semi-structured interview where you will be asked to explore your experiences of working on this ward. With your consent, the interview will

be audio taped and transcribed. However, to maintain confidentiality your identity will be concealed by the use of pseudonyms throughout this process.

Following the interviews a preliminary analysis of the data collected will be written and distributed to each participant, along with a copy of the transcript of their individual interview. The preliminary analysis will identify themes and issues that were raised in the interviews.

You will then be asked to attend one group discussion that will also involve the other interviewees. At this discussion you will be asked to reflect on and further explore the issues raised in the preliminary analysis. With your permission, this discussion will also be audio taped and transcribed.
You will be asked only to contribute information that you feel is relevant to the study, and that you are willing to share. All data collected during the course of the study will be regarded as confidential. You will be free to withdraw at any time without prejudice

Prior to the commencement of the project you will be asked to sign a statement of informed consent. At the conclusion of the project, you will be given a copy of the thesis detailing the results of the study.

CONTACT PERSONS:

If you have any questions or concerns about the study please contact:

Andrew Robinson
Lecturer in Clinical Nursing
University of Tasmania
Locked Bag 1-322
Launceston, TAS, 7250.
Ph. (03) 63 244008
E-mail Andrew.Robinson@utas.edu.au

Annette Marlow
Master of Nursing Student
University of Tasmania
Locked Bag 1-322
Launceston, TAS, 7250.
Ph: (03) 63243084
E-mail Annette.Marlow@utas.edu.au

Ethics approval has been received from both the Launceston General Hospital ethics committee and the University Human Research Ethics Committee.
If you have any concerns of an ethical nature or complaints about the manner in which the project is being carried out, you may contact:

Ms. Amanda McAully
Executive Officer
Human Research Ethics Committee
Office of Research

Prof. Janet Vial
Chairperson
Human Ethics Committee
(Human Research)

University of Tasmania
Sandy Bay, TAS, 7000
Ph (03) 62 262763

University of Tasmania
Sandy Bay, TAS, 7000
Ph (03) 62262763

Appendix 2 - Consent form

Title of project **Just a Nurse: How do nurses who work on a general medical ward regard their practice.**

*A statement by the **participants'*** in the following terms:

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves the following procedures:
   - An interview with the student investigator. This will take about one hour, and will be audio taped and transcribed.
   - The transcript of the interview will be returned to me, for member checking. I will also receive an 'issues paper' which will contain a preliminary analysis of the issues and themes identified from all the participants' interviews. I will read this document prior to meeting with the group.
   - All the participants will meet for a group discussion with the student investigator. This meeting will address the issues raised in the previous interview and the 'issues paper'. This will be audio taped and transcribed.
4. I understand that anonymity cannot be maintained between participants once we meet as a group. However you will be asked to keep the discussions that take place during the group meeting in confidence. You will also be expected to disclose only that information which you volunteer and feel comfortable with.
5. I understand that all research data will be treated as confidential.
6. Any questions that I have asked have been answered to my satisfaction.
7. I agree that research data gathered for the study may be published provided that I cannot be identified as a subject.

8.* I agree to participate in this investigation and understand that I may withdraw at any time without prejudice.

Name of participant .....

Signature of participant ..... Date .....

9.* *A statement by the **investigator*** in the following terms:

I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

Mr. Andrew Robinson (Chief investigator)	Signature	Date
Mrs. Christina Bobrowski (Co-supervisor)	Signature	Date
Ms. Annette Marlow (Student researcher)	Signature	Date

Appendix 3 - Discussion paper

The story so far..... A Discussion paper

First of all I would like to thank you all for participating in this research project, and for the honest opinions and descriptions that you gave of your experiences. These accounts formed the basis of this paper.

It is my intention that the paper will encapsulate for the group, what you have said, highlighting the key issues. Some of the issues were common to all of you and some unique to individuals. This paper will set the scene for our upcoming group discussion. The purpose of us meeting as a group is to critically reflect on and discuss these issues in greater depth.

As such it is intended that this paper will create a 'spring board' from which discussion and clarification can occur. Please do not feel that you have to agree with the way I have analysed the issues presented, or that the discussion must be limited to the issues raised here. Nothing in this paper is set or fixed and is all open for discussion, so if there is anything in this paper which concerns you we can discuss and clarify as necessary.

My provisional analysis may challenge or reaffirm the way you feel about what you do as a general medical ward nurse. It is hoped that this study is creating an opportunity for you to speak to your experiences.

Please note that to protect your confidentiality I will assign a pseudonym at random, these pseudonyms can be altered at the group discussion.

Professional Satisfaction

The increased complexity of healthcare and the associated increased demands on medical nurses led some of you, in our conversations, to describe yourselves as multitalented and multiskilled. Your accounts suggest that caring for often complex patients requires that you piece together fragments of information to gain a broader perception of a patient and their illness experience. Your comments indicate that your depth of experience as a medical nurse allows you to make sound clinical judgments. As Jane recounted '*because I have been nursing for such a long time, I really am quite good at knowing when people aren't well ... I bring with me a whole range of skills and experience*'. This view was supported by Julie, who argued:

I have found that I have built up an incredible repertoire of knowledge and skills that I don't even realise I've got until I come to a situation. It's totally different and I apply all that knowledge and I can make a decision very quickly, and very confidently. If I can't, I've got the experience to be able to identify and utilize another resource.

Further reflective of the importance of this knowledge base, Jenni further suggested that her ability to '*put all of the pieces of the jigsaw together*' is '*what keeps me there*'. Such

comments are suggestive that having these abilities is the source of some professional satisfaction. It is as if you are affirmed of your worth as a medical nurse because of your ability to successfully manage complex situations.

Analysis of your accounts also suggests that you value the importance of having a sound practice base and a thirst for knowledge. Indeed, your comments imply that this quest for knowledge confirms for you why you chose medical nursing as your area of practice. As Jane recounted 'It's [medical nursing] *challenging, stimulating, there's no better place to learn'.*

What Makes Medical Nursing Satisfying

When each of you discussed those aspects of medical nursing that sustained your practice, you all spoke of the diversity, complexity and intricacies involved with the provision of patient care. It was also apparent that you believed having a high level of competence was important because of the increased demands associated with working on an acute medical ward. You all spoke about the diversity of patients with regard to their diagnosis and the specific skill level required to provide appropriate nursing care. This was important because as one of you noted, the diagnoses of the people under your care ranged from *absolutely anything and everything.* Given this, you all argued it was essential to have a high skill level to work in this area.

Reflective of your comments, *'absolutely anything'* referred to those patients requiring interventions for acute illness, chronic illnesses or associated treatments. Also your accounts indicate that there has been a marked increase in the acuity of patients now nursed on medical wards. Analysis of your transcripts suggests that as medical nurses you are now expected to care for far greater numbers of acutely ill people. It seems many of your patients now routinely require 'intensive' nursing that was previously delivered in specialist high dependency units such as CCU or ICU's. For example, Jenni reported that *'we now get patients that used to go to ICU, the patients that we would never see until later on in their hospital admission, we now get immediately'.* Julie further suggested *'it's not uncommon now for someone to have a cardiac arrest and we resuscitate them on the ward and stay on the ward...whereas 4-5 years ago they would go up to ICU straight away'.*

As stated in the discussions, these patients formed part of a collective group of people nursed on the ward who had enormous diversity of diagnoses and related co-morbidities. Julie clearly articulated this when she reported that 'Most *of the patients would have some kind of a chronic medical condition, often concurrent medical conditions together'.*

Throughout the interviews each of you made reference to an eclectic array of patients requiring nursing care on your ward. These included what you termed *'the acute patients', 'the chronic patients'* and the *'non-acute patients'.* For the record it's probably useful to reiterate the types of patients and diagnosis that these groups comprise of. The 'acute' group included those patients who had recently had a renal, cardiac or lung transplant, patients with acute renal disease, acute cardiac, respiratory or endocrine disease. This 'acute' group also included surgical patients, who for reasons such as bed

shortages on the surgical wards, were admitted to a medical ward. Surgical patients were also admitted to medical wards following a post surgical illness episode, such as stroke or a myocardial infarction. According to your accounts, other acute illnesses included acute confusional states and those patients in the process of withdrawing from alcohol or drugs.

Analysis of our conversations revealed a second group. These were the patients with chronic diseases, who often had concurrent medical problems. As Julie clearly articulated, 'Diabetic *patients usually have cardiac disease and perhaps a respiratory disease, with perhaps a UTI, or an infected leg ulcer... that's a general patient'.*

Such is the nature of co-morbidity in some patients, that they are frequently admitted on the basis of, as Sophie suggested, '*diagnosis for investigation'.* Sophie went on to explain that such a diagnosis meant *'we'll figure it out later'.*

Finally, as was highlighted in your conversations, another group mentioned by all of you were those classified as '*non-acute'.* According to Jane, this group represented a high proportion of the patient mix on her ward, and as she noted, these patients were *'more long term'.* Jane went on to explain, saying *'they might come with an acute illness and then for one reason or another are* [subsequently] *classified non-acute and are therefore waiting for nursing home placement'.*

A number of you also referred to a phenomenon, where elderly patients were admitted to your ward for acute treatment and then remained as inpatients while awaiting placement in a nursing home. This phenomena seemed to frustrate some of you, and this became most apparent when you used language such as, *'old age for investigation'*, 'bed-*sitters'*, *'the dregs'* and *'social admissions'* to describe these elderly patients. Indeed, one of you further commented that the increasing numbers of what the literature refers to as 'bed blockers', meant that your ward had become a *'real dumping ground'.* It was a phenomena exacerbated at Christmas when it was labelled as *'Granny dumping'* by Jane. It could be argued that the use of such language suggests a specific ageist agenda at work in the hospital, where elderly patients who require minimal interventional treatment are considered as being less worthy of care. It was interesting to note that despite the depreciating language used to describe these patients, suggestive that their needs were minimal; at the same time many of you articulated that they actually required very complex nursing care. For example, because generally they had so many concurrent medical problems these patients required comprehensive and detailed discharge plans. Therefore I would like you to think about these questions - How well does the language used to describe these patients reflect their needs? Furthermore how specific is the use of this language to this area of nursing and in what way does it affect how you see your work?

Responsibilities of a medical nurse

Given the diversity and complexity of the patient mix it was not surprising that you all argued that to be effective as a nurse in this area you needed to be an experienced practitioner with an extensive knowledge base. This was clearly articulated by Julie when she said:

A medical ward nurse is a super nurse, has everything under her belt, has to be knowledgeable, has to be able to think very quickly, be perceptive and be able to pick up on little things, to be able to deal with stress, to deal with conflict, to a certain extent be physically fit, because you're running around and lifting and bending and doing quite a lot. You need to be a counsellor, you need to be a social worker, you need to be a hairdresser and a florist.
Being a nurse is not just putting on a white dress and giving someone a shower, there's so much that you need to do...it's becoming more evident that you have to know more and more...so far as what we need as a nurse on a medical ward, its probably easier to tell you what we don't need, because there's less of it.

Given the nature of the work and complexity and diversity of patients nursed on these wards, again it was not surprising that you all described a broad range of responsibilities associated with your role. These included clinical management, administrative management, the provision of staff support and leadership, as well as the supervision of students, graduate nurses and new staff.

In terms of clinical management, because of your level of expertise you all stated that on any given shift inevitably you cared for the *'sickest patients'*. I would like you to think about this statement, so that we can describe, at our group meeting, who are the sickest patients, and what are the implications for you and your practice when caring for these patients?

Additionally you all made mention of your significant involvement in the resolution of complex family issues. However it is unclear what you meant, and how this impacts on your role.

With regards to your administrative responsibilities, they included being 'in charge' on an evening shift and at weekends. From your comments it seems that being rostered for evening shifts and weekends occurs very frequently. In this capacity you described being responsible for monitoring the status of all of the patients on the ward, organizing often complex discharge planning procedures as well as emergency patient transfers and ensuring adequate staff for oncoming shifts.

In the interviews you also articulated your responsibilities with respect to the provision of staff support and leadership. Your accounts suggest that you assumed this responsibility on any given shift, and that this was not always associated with 'being in charge'. Usually this involved you taking on the role of a resource person for all staff on the ward and organizing on-going staff development sessions. Finally you all argued that because of your high level of knowledge and experience, your supervisory responsibilities included mentoring new and graduate staff, as well as preceptoring student nurses. The extent of your responsibilities was clearly encapsulated by Jane who suggested:
I am there for all the patients ultimately. I will always have staff coming to ask me questions...I get pulled away to do things, like taking the difficult bloods, just taking ECGs, escorting patients to and from procedures...Ultimately on a medical ward there are a lot of junior staff... So they come up to you on a constant basis asking questions,

not sure about assessments, so you end up assessing a lot of other patients in between and just dealing with all the management stuff, like phone calls that other staff can't deal with.

Competing Tensions

As identified in the interviews, you argue that your depth of knowledge and level of experience enables you all to care for often complex and complicated patient needs on a medical ward. However with this knowledge and experience comes the added perception that you have the capacity to take on the extra supervisory, administrative and clinical responsibilities. Interestingly your accounts of practice suggest, in the wider scheme of things, the latter responsibilities as outlined above, are often unacknowledged. This was cause for concern because analysis of your transcripts revealed a balancing act between competing demands. That is, on the one hand you express a sense of responsibility to prioritise care associated with the increased acuity of the patients on your ward. However, it appears that this sits in tension with the professional responsibility to provide an adequate standard of care to all patients regardless of their level of acuity and need for acute nursing care. To make matters worse it appears as if this tension is cast within the context of escalating levels of responsibility associated with the varying levels of staff experience, ongoing budgetary restraints which limit the numbers of available staff, and a need to adequately care for those patients who have been allocated personally to you on any given shift.

This tension had many implications. For example, many of you commented that you were unhappy, and that your colleagues on the medical wards were unhappy. Some of you articulated that your unhappiness related to the constant pressure 'to get the job done'. As many of you argued, this was because of the dominant imperative to prioritise the provision of technical care over body care. Your struggle to manage this tension has seemingly challenged your identity as nurses. In this sense, your comments highlight a strong sense that you feel caught between the role of nurse as carer and nurse as technician. My analysis suggests that managing this tension often meant that the person/patient is 'juggled' between your caring role and the need to fulfil the more technical aspects of patient management. Most of you articulated this tension as an every day aspect of your life as a medical nurse. It was a reality of practice. Your comments indicate that in response you experienced guilt as you struggled to prioritise the body care against the technical care. This became evident when Sophie suggested:

We can't provide the nursing care that we want to provide and should be providing, because we are so busy. We are dealing with so many issues. They're [the patients] not getting the hands on nursing care or the time that they feel they deserve and they're unhappy. You can tell that they are unhappy, we don't get as many chocolates now and thankyou letters. There are a lot of complaints put into about the ward. It's not targeted at the nursing staff or saying a nurse is bad or done anything bad, it's due to lack of care and that's simply because of staffing levels'.

This comment suggests that like the nurses, many patients on the ward are unhappy because the nurses are unable to meet their care needs.

Your comments suggest that many patients *'miss out'* on care they require because of the

'busyness of the ward' and the dominance of the aforementioned medical-technical imperatives. Indeed Jenni suggested that it was generally the less acute patients who 'miss out'. She argued that:

'Often the elderly who have dementia don't get the level of care that they require on an acute ward, no-one seems to have the time...they don't get the care that they deserve...we have to prioritise and that prioritising is becoming more finely split to the point where patients who have fundamental needs and often those needs involved are issues of dignity, have to be left, to look after the acute patient'.

However, in the context of a busy ward with patients who have highly diverse needs, on occasions it appears that the 'acute' patients also 'miss out' on receiving nursing care. Julie argued this, commenting that:
'Unfortunately on the ward you will have a situation where you will have someone who is being rather disruptive or potentially dangerous and you need to settle that patient down or quieten that patient down and unfortunately there are more acute patients that require a lot of assessment and management during the course of the shift, these patients will miss out [on nursing care]...which I don't think is fair but it's just the nature of the ward'.

Comments such as these suggest that the way in which care is prioritised on your wards, whether it be technical care versus body care, means that the patiens inevitably 'miss out' on the care they require. It seems that managing this tension is what causes you a great deal of angst - it's a balancing act. Am I understanding you correctly?

According to most of you, changes in patient acuity have also impacted on the way you focus your nursing care. How then do you feel when you are too busy to fulfil those aspects of nursing care that you see as pivotal to fulfilling your role as a nurse?

Analysis of your transcripts further revealed that as nurses working on an acute medical ward, the lack of recognition and support to help you manage these and other competing demands, has left you feeling devalued, frustrated, unhappy, and tired.

In this sense a key issue identified in all conversations was your sense of being devalued, devalued because of the types of patients you care for and generally their low status. Your comments indicate that these people are afforded a low status because of the perception that patients nursed on the medical ward require little more than body care, and as such require little in the way of medical treatments and interventions. Indeed Julie argued that *'I think that people would say that you're there* [as a medical nurse] *doing the big heavy sponges and the showering and the toileting and the hauling in- to bed.'* In part there is an element of truth in this perception, as you all recounted going home from work very tired because of the often physical nature of your nursing. However, Julie clearly articulated that the lack of appreciation of the complexity also associated with medical nursing was in part a consequence of the work of medical nurses largely being *'totally invisible and unacknowledged'*. Following on with this notion of invisibility it is interesting to note that the literature suggests, that body care is often associated with the

hidden and menial work [associated with nursing] and therefore has a relatively low status (Lawler 1991:222).

The issue of status was highlighted by Sophie when she alluded to the dominant interpretation of medical ward nursing as constructed by 'surgical nurses'. She claimed that:
The surgical nurses see our work as being very easy and boring, when in fact they don't really understand that we certainly have the acuity that they have...They think of us as a lower form of nursing because we deal with all of the full nursing care patients and the nursing home patients...they see us as at the bottom of the ladder.

It is interesting to note that some of you commented that in your experience student nurses also construct medical nursing as menial and uninteresting. As Jenni stated, 'they *see it as less exciting...almost like a nursing home'* This view is supported by the literature, which suggests that 'body care' is often termed as 'basic care'. Lawler (1991:62) argues that this implies 'a lack of skill and importance'. The above comments suggest that working on a medical ward, in the scheme of things, is not prestigious or high in status. Jane made this point when she said:
There definitely seems to be more prestige along with I'm an ICU nurse or I'm a ER nurse...Where if you're a medical nurse, you might have a specialty on the ward, but you don't call yourself a renal nurse or a cardiac nurse...you're just a nurse...your just a general medical nurse.
This language suggests the operation of a hierarchy within nursing, with those nurses performing primarily body care, the medical nurses, being situated at the lower end of the scale.
Further indicative of your status, many of you also expressed concerns that you felt devalued by your 'nursing managers'. This became apparent when the issue of staff to patient ratios was raised. For example, most of you argued that while the surgical wards of the hospital were adequately staffed, with regard to patient acuity, that this was not so on the medical wards. Indeed as one of you noted:
...I'm constantly frustrated...particularly when you talk to people working on the surgical side...they say we've got 30 patients and 8 nursing staff and we're [on the medical ward] struggling with 6 and 32 patients. So that makes you quite frustrated and very bitter because it's the whole hierarchy.

Reflective of the apparent lack of status associated with medical nursing within the hierarchy of care, one of you further argued that you have to *'fight'* for extra staff, when staffing levels are low, *'because of the budget'.* These and other statements suggest that you believe that medical wards are discriminated against with respect to resources and it is evident that you perceive consequent budgetary constraints as a practice reality.

Through further reading, it has become evident to me that the more closely nurses are linked to technology, the higher their status. How does this make you feel when many of the patients that you care for require minimal technological interventions but maximal 'hands on' nursing care, and what are the implications for medical nursing? One implication may be the status of the team on a medical ward?

Taking the team out of team work

Indeed, throughout all of my conversations with you another key issue emerged as a source of your unhappiness. My analysis suggests that while you all desire to be a part of a 'team' within the context of the problems outlined in this paper there is a lack of team ethic on your wards and this is strongly associated with a diminished desire to stay working on the ward.

Reflective of your concerns with the team ethic, your descriptions also highlight the lack of collegiality, indeed as one of you recounted...*you can walk on to a ward and there can be a sense of gregariousness, people are talking and chatting and laughing...that's not always authentic ...that comes at the expense of genuine collegial colleagueship.* It is apparent from this narrative fragment that there is a degree of superficiality between your colleagues and this superficiality impacts on your practice. However I would like you to think about the notion of teamwork. What makes for an effective team on your ward? And if the team is 'unhappy' who ultimately suffers?

Conclusion

Your transcripts highlight for me the importance of this study. The need to be heard and the need to have a voice as a medical nurse has been clearly identified. As one of you so clearly articulated, *'Too many of us view ourselves as oh I'm just a nurse, just one of the girls, we don't really articulate our needs, we're ashamed of saying that we want to be acknowledged'.*

The issues discussed are those I believe reflect the defining characteristics of a general medical ward nurse as well as those aspects of practice that you find frustrating and challenging. I am hopeful that this paper will facilitate further discussion and clarification.

Where to from here...

I will contact each of you in the following days to organize a date and time for our group meeting. Please feel free to contact me at any time prior to this. My phone number is: 0419893392. Thank you for your support.

Appendix 4 - Ethics proposal

UNIVERSITY OF TASMANIA

Research and Development Office
GPO Box 252-01
Hobart, Tasmania 7001 Australia
Tel: 03 62262763 Fax: 03 62267148
Email: Human.Ethics@utas.edu.au

HUMAN RESEARCH ETHICS COMMITTEE

APPLICATION: INVESTIGATION INVOLVING HUMAN SUBJECTS

INVESTIGATION NUMBER (Office use)
TITLE of proposed investigation [i] Just a Nurse: How do nurses who work on a general medical ward regard their practice?

A. OUTLINE OF PROPOSAL

Applicants [ii]

Title/Name	Position	School or Discipline
Mr Andrew Robinson (Chief Investigator)	Lecturer in Clinical Nursing	Tasmanian School of Nursing
Mrs Christina Bobrowski (Co-supervisor)	Lecturer in Clinical Nursing	Tasmanian School of Nursing
Ms Annette Marlow (Student Researcher)	Master of Nursing student	Tasmanian School of Nursing

Contact details for chief investigator

'Phone 63 243024 Fax 63243952 Email Andrew.Robinson@utas.edu.au

Purpose [iii]

To explore the experiences of general medical ward Registered Nurses.

This research is being conducted as a partial requirement of the Master of Nursing (course work) the purpose of research.

Aims [iv]

This qualitative study uses a critical research methodology with the aim to:

- Investigate the experiences of Registered Nurses' and reveal issues that are significant to their nursing practice whilst working as general medical ward nurses.
- Explore the possibilities for Registered Nurses' to develop new insights and understandings which may potentially enhance their nursing practice.
- Promote the motivation and impetus for further research into issues surrounding the practice of nursing.

Justification [v]

The knowledge and technology explosion in health care has necessitated that groups of nurses focus on particular patient populations. To meet patients more specialised needs nurse have developed more specialised knowledge (Appel & Malcolm, 1996). Professional nurses have continuous learning needs as a result of the escalating use of technology and an expanding body of scientific knowledge (Berger et al. 1999). In response, universities around the country offer an increasing number of postgraduate (previously called post-basic) courses at the certificate, graduate diploma, masters and more recently, doctoral level, across a range of practice specialties (Appel &Malcolm, 1996). In my experience, few first year Bachelor of Nursing students envisage a future career for themselves on a general medical ward caring for the predominantly elderly patient. Rather, they are already considering which specialty they should pursue. Indeed there is a significant body of literature which outlines student preference for specialist career paths rather than aged care, reflecting a growing interest in specialisation. Recent studies indicate that health professionals perceive working in general medical ward as either low status or low prestige (Happell 1998: Herdman, 1998). Similarly, caring for the aged is often perceived by both graduate and student nurses as custodial, unchallenging and unrewarding, and generally the more 'basic' the work, the lower its status (Herdman, 1998: Happell, 1999: Stevens & Crouch, 1995). Meanwhile, the reality in the health system is that though there may be a shift towards shorter hospital stays, community based care and the necessity of specialization of skills related to increases in technological innovation, a large number of nurses work and deliver care in a ward setting at the bedside.

This study will focus on nurses who practise as 'generalists' within the context of a general medical ward setting. It is concerned with uncovering the ways they make sense of their work as 'generalist nurses' and the issues that impact on their practice.

Period of investigation [vi]

Commencement date March 2002 Completion date November 2002

Funding [vii]

Source/potential source of funding and amount: Nil

Do the investigators have any financial interest in this project? NO

Review of ethical considerations [viii]

Has this protocol previously been submitted to the University Ethics Committee? NO

YES

Does this project need the approval of any other Ethics Committee?
If 'YES', what is its current status?
University of Tasmania Social Sciences Ethics sub-committee

Relevant references

Appel, A. and Malcolm, P. (1998), Specialist education and practice in nursing: an Australian perspective, *Nurse Education Today, 18:1 44-52.*
Berger, A., Eilers, J., Pattrin, L. et al. (1999), Advanced practice roles for nurses in tomorrow's healthcare systems, *Clinical Nurse Specialist,* 10: 250-255.
Happell, B. (1999), "We may be different, but we are still nurses": An exploratory study of drug and alcohol nurses in Australia, *Issues in Mental Nursing,* 20: 19-32.
Herdman, E. In: Keleher, H. and McInerney, F. (1998), *Nursing Matters: Critical Sociological Perspectives,* Churchill Livingstone, Australia, 160-163.
Stevens, J. and Crouch, M. (1995), "Who cares about care in nursing education?" *International Journal of Nursing Studies,* 32:3, 233-234.

B. PROCEDURES

Detailed procedures [ix]

Following the granting of approval to conduct the project by the Director of Nursing of the Launceston General Hospital, and consultation with the Clinical Nurse Consultant of an acute medical ward, the student investigator will meet with Registered Nurses on the ward to:

- discuss the proposed study
- inform them of what will be required of them should they wish to participate, and
- to recruit participants' for the study

Following recruitment, a meeting will take place to elaborate on the nature of the project.

In order to enable them to make an informed decision about participating in the study, an information sheet which addresses the aims and procedures of the study will be provided.

Their written consent to participate in the study will be obtained.

A qualitative methodology, with a critical intent, will be utilized for this study.

Three stages will be followed.

Stage One:

A one hour unstructured interview will be conducted with each participant. The interview will be audio taped and transcribed. The transcripts of individual interviews will then be returned to the respective participants

Stage Two

Involves the conduct of a preliminary analysis of the data collected from all interviews. This analysis will identify emerging themes and issues related to the nurses' experience in being a 'generalist' nurse on an acute medical ward. This will be developed into an issues paper which will be returned to all participants prior to the next stage of the study commencing.

Stage Three:

The five participants will attend a focus group meeting and engage in discussion where the issues raised in the above paper will be addressed.

With the participant's permission, the focus group discussion will be audio taped and transcribed.

Where is this project to be conducted?

- The study will be conducted in an acute medical ward in the Launceston General Hospital.
- The interviews and focus group discussion will be conducted at a place that is convenient and suitable to the participants'. Possible venues include the Anne O'Byrne Centre at the Tasmanian School of Nursing, University of Tasmania, or the participant's place of residence.

SUBJECTS

Selection of subjects [x]

- A convenience sample of five registered nurses who work in two hospital wards will be recruited for the study.
- The participants recruited will ideally be nurses with three years or greater post - graduate experience who have been employed on the ward for at least two years.

Registered Nurses with this level of experience will be selected as they will be well engaged in the issues confronting general medical ward nurses.

Recruitment of subjects [xi]

- The participants will be recruited following a discussion with the Registered Nurses on the wards in which the study will be conducted, in order to inform them of the nature of the project and the requirements of participation.

Information about subjects

(i) State whether information will be identified, potentially identifiable or unidentified. [xii]

- Information will be obtained through individual interviews and a group discussion. Personal information may be disclosed at times; hence pseudonyms will be used both in text and the transcripts to ensure confidentiality. Any identifying characteristics will be concealed at the time of transcription. Similarly, the discussion paper returned to the participants will conceal any identifying characteristics.

(ii) State source(s) of information. [xiii]

- Audio taped interviews and focus group discussion.
- Transcriptions of interviews and focus group discussion.

(iii) Will data on individual subjects be obtained from any Commonwealth Government agency? [xiv]
If so, name agency.

- No.

Potential risks [xv]

Nil

Post contact [xvi]
Post contact will not be made unless participants request this to happen. Participants will be offered a copy of the completed thesis.

Remuneration [xvii]

There will be no financial remuneration or other rewards offered to the participants other

than for out of pocket expenses.

Confidentiality and anonymity [xviii]

Audio tapes and transcripts will be stored in a locked drawer in the office of the chief investigator at the Tasmanian School of Nursing, Launceston. Tapes and transcripts will be kept for a period of five years and then destroyed.

Participants will not be referred to by their real names in the transcripts or the text as pseudonyms will be used to protect their confidentiality.

In order to ensure anonymity in stage two all identifying characteristics will be erased from the transcripts of interviews and the discussion paper distributed to participants.

During stage 3 the participants will be asked to maintain confidentiality regarding issues discussed during the group discussion. Maintaining anonymity in this stage will not be possible as the participants meet as a group.

Administration of substances/agents [xix]

- No

Human tissue or body fluid sampling [xx]

- No

Other ethical issues [xxi]

- No

Information sheet [xxii]

- Please see attached document

Consent form [xxiii]

- Please see attached document

C. DECLARATIONS

Statement of scientific merit [xxiv]

The *Head of School** is required to sign the following statement:
This proposal has been considered and is sound with regard to its merit and methodology.

Dr Gerald Farrell

* In some schools the signature of the Head of Discipline may be more appropriate.
* The certification of scientific merit may not be given by an investigator on the project.

Conformity with NHMRC guidelines [xxv]

The *chief investigator* is required to sign the following statement:
I have read and understood the *National statement on ethical conduct in research involving humans*
1999. I accept that I, as chief investigator, am responsible for ensuring that the investigation proposed in this form is conducted fully within the conditions laid down in the *National Statement* and any other conditions specified by the University Human Research Ethics Committee.

Dr Andrew Robinson

Conformity with code of practice: human tissue and body fluid sampling

The *chief investigator* is required to sign the following statement in relation to relevant research projects/teaching exercises:
I have read the Human Research Ethics Committee *Code of Practice: Human Tissue and Body Fluid Sampling* and confirm that this Code will be followed.

Dr Andrew Robinson

Signatures of other investigators [xxvi]

Mrs Christina Bobrowski

Ms Annette Marlow

ENDNOTES

[i] Title: Please be concise but specific. Titles should be consistent with those used on any external funding application(s). For teaching practicals please give code and title of course.

[ii] Applicants:
The term 'investigator' is used to cover staff and students in their roles as researchers or educators.
Show chief investigator first. The chief investigator is responsible ultimately for the conduct of the project. Student researchers may not be named as chief investigators. Supervisors will therefore normally be the chief investigators for projects undertaken by students. The student's academic level (eg 3rd year; Honours; PhD) must be shown.
All applicants must sign the form (Section C: Declarations)

[iii] Purpose: State whether this is a research project or a teaching exercise. Using students as experimental subjects in a class practical is an example of a teaching exercise using human subjects.

[iv] Aims: Please give a concise description of the main objectives and/or hypothesis of the study.

[v] Justification: Explain why this particular study is worth doing; and the main advantages to be gained from it.

[vi] Period of investigation: Give expected commencement and completion dates of the investigation.

[vii] Funding: Under the *National Statement* (2.21) a researcher must disclose (i) the amount and sources or potential sources of funding for the research; (ii) any affiliation or financial interest. In some cases there may be a risk that potential subjects will be coerced or induced to participate.

[viii] Review of ethical considerations: If this project has been approved by any other Ethics Committee provide evidence of this approval.

[ix] Research procedures: The experimental plan and procedures must be described in detail. Please use language which will be understood by the non-specialist. Be specific about what each subject will be asked to do.
If a questionnaire or interview will be included, outline the kinds of questions that will be asked. If you have prepared a draft questionnaire or interview schedule, include these with your application. This will prevent delay in the event that the Committee wishes to see them.

[x] Selection of subjects:
Clearly describe the experimental and, where relevant, control groups. Include details of number of subjects, sex, age range, special characteristics. Give a justification for your choice of subject group/s.

[xi] Recruitment of subjects:
Explain in detail how subjects will be recruited. Investigators frequently provide insufficient information on how subjects will be approached. Committee members need this information so that they can check, for example, that individuals' privacy is not infringed; that there is no coercion to participate; and that subjects are given adequate time to decide whether or not they wish to participate.

[xii] Categories of information:
In the *National Statement* (Preamble) information is categorised as identified (data that allow the identification of specific individuals), potentially identifiable (coded, re-identifiable) or de-identified (not re-identifiable, anonymous). Particular care is required where the research involves identified or potentially identifiable information.

If personal (identified or potentially identifiable) information will be collected in this study give details of the information that will be collected.

[xiii] Source(s) of information:
In many research studies information about subjects is obtained from sources other then the subjects themselves. Care must be taken to ensue that an individual's personal information is protected against unauthorised collection or disclosure.

[xiv] Information obtained from Commonwealth Government agencies:
If you wish to obtain data containing personal information from any Commonwealth Government agency state the names of these agencies, describe the nature of this data and explain the justification for obtaining this information. At the Commonwealth level the collection, storage, use and disclosure of personal information by Commonwealth agencies is regulated by the *Privacy Act* 1988. The NHMRC requires the Ethics Committee to provide information on the cases in which it has approved access to, and use of, data held by Commonwealth Government agencies.

[xv] Potential risks:
Any significant physiological, psychological, social or legal risks associated with this investigation must be disclosed. The investigator must include any possible risks or effects that might affect a person's willingness to participate in the study, eg:

- the possibility of physical harm, pain or discomfort above the everyday norm;
- the possibility of emotional distress, anxiety or embarrassment above the everyday norm in the subjects or others;
- obtaining information which may be prejudicial to participants (eg there would be a risk of social harm or legal implications if information was disclosed).

Explain the precautions to be taken to prevent or minimise risks.

[xvi] Post contact: Explain the procedures to be followed to establish the well-being of the subjects when the study has been completed (if post-contact is appropriate).

[xvii] Remuneration: Volunteers may be paid for inconvenience and time spent, but such payment must not be so large as to be an inducement to participate. If payment is to be made include the reasons for payment and the timing of payment(s).

[xviii] *Confidentiality:*
Confidentiality of information is protected when it is not disclosed or revealed to other persons by the investigators. How will data security be maintained during the project? How will data be stored after the project has finished? How will it be disposed of?
Anonymity:
Anonymity means that individual subjects are not identifiable. In some studies, eg many surveys and questionnaire-based studies, individual subjects' names are not recorded. In other studies identifying information is collected and measures must be taken to maximise the security of this information. How will anonymity of subjects be assured?

[xix] Administration of substances/agents: If any chemical compounds, drugs or biological agents will be administered specify name of substance, dose and frequency of administration, total amounts to be administered and anticipated effects.

[xx] Human tissue or body fluid sampling: If the project involves human tissue/body fluid sampling full details must be provided. Specify what will be sampled and how; frequency and volume; how samples will be stored and disposed of; who will take the samples and

their qualifications for this; potential risks.

The chief investigator must follow the Ethics Committee's 'Code of Practice: Human Tissue and Body Fluid Sampling' (see Section C: Declarations). This Code is included in the handbook *Human Research Ethics.*

[xxi] Other ethical issues: If, in your opinion, this project raises any other ethical issues please give details.

[xxii] Information sheet: With few exceptions, it is essential that subjects are provided with an information sheet. The Committee will pay close attention to the information that is given. An outline of the information that normally needs to be covered follows the application form. A copy of the proposed information sheet must be included with your application form.

Please take care to include the contact persons for concerns or complaints. This is a requirement in the *National Statement* (2.40).

[xxiii] Consent form: Written evidence of consent is usually required for research involving human subjects. A sample consent form follows the application form. The format of the sample form is appropriate for most projects. If written consent is to be obtained a copy of the actual consent form that you propose to use must be included with your application form.

While written consent is the norm, there are various kinds of studies for which other procedures for obtaining consent are more appropriate. See 4.5 in the Handbook. If you consider that written consent is inappropriate for this project please give your reasons on the application form.

In special circumstances the Ethics Committee may give approval for consent to be waived. For information see 4.5 in the Handbook.

[xxiv] Statement of scientific merit: The Head of School's (or Head of Discipline's) signature on the application form indicates that he/she has read the application and confirms that it is sound with regard to (i) educational and/or scientific merit and (ii) research design and methodology. If the Head of School/Discipline is one of the investigators this statement must be signed by an appropriate person. This will normally be the Head of School/Discipline in a related area.

This does not preclude the Committee from questioning the research merit or methodology of any proposed project where if feels it has the expertise to do so.

[xxv] Conformity with guidelines and codes of practice: The chief investigator is asked to sign to accept the conditions listed in these sections.

[xxvi] Signatures of other investigators: The other investigators should sign to acknowledge their involvement in the project and to accept the role of the chief investigator.